

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince George's  
City or town Cheverly, Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 63 days  
Hospital, institution, or street address where death occurred:  
Prince Georges Hosp.  
How long in hospital or institution? 63 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Prince Georges  
City or town 2801 Landon, Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4919-28th Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Hood (Ayres,) Mrs Sodie

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced W  
6.(b) Name of husband or wife  
7. Birth date of deceased (mo., day, yr.) Oct 10 - 1884 6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 63 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Penna  
(Town, county, and state)  
10. Usual occupation housewife  
11. Industry or business  
12. Name klatlik strikes  
13. Birthplace unknown  
14. Maiden name unknown  
15. Birthplace

16. Informant Harvey ayres  
Address West, Landon Md  
transportation Date thereof April 7, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory West Newton Embury  
Location West Newton Penna  
18. Funeral director F Gasch's sons  
Address Hyattsville Md  
19. 4/7 48 Amanda Downey  
(Entered by registrar) Registrar

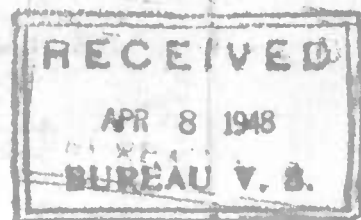
### MEDICAL CERTIFICATION

20. DATE OF DEATH 6 April 1948 at 10:05 A  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 1948 to April 6 1948  
and that I last saw him alive on April 6 1948  
Immediate cause of death Left ventricular failure  
Due to Coronary thrombosis  
Due to arteriosclerosis  
Other conditions diabetes mellitus  
Cholelithiasis + Cholelithiasis  
(Include pregnancy within 3 months of death)  
Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE Albert Roth, M.D.  
Address Landon Date signed April 6, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this certificate are especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Lanham  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 42 years.  
 Hospital, institution, or street address where death occurred:  
Princess Garden Road.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George  
 City or town Lanham  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Princess Garden Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Gertrude Baldwin

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Henry T Baldwin  
August 1, 1873 6.(c) If alive, give age 75 years  
 7. Birth date of deceased (mo., day, yr.) Nov. 19, 1874  
 8. AGE: Years 73 Months 4 Days  If less than one day  
 hrs.  min.

9. Birthplace Washington DC  
 (Town, county, and state)  
 10. Usual occupation House wife  
 11. Industry or business

FATHER 12. Name Ruben H Harlow  
 13. Birthplace Virginia  
 MOTHER 14. Maiden name Joanna Cowne  
 15. Birthplace Virginia

16. Informant Miss Charlotte Baldwin  
 Address Lanham Maryland  
 17. Burial Date thereof April 3, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Lincoln  
 Location Washington DC

18. Funeral director S. Pasche Sons  
 Address Hyattsville Md.

19. 4-2 1948 Mrs Jack Bennett  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948 at 2:30 A.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec 1 1947 to Apr 1 1948  
 and that I last saw h. or alive on March 31 1948

Immediate cause of death Hypostatic Pneumonia DURATION 48 hrs

Due to Metastatic lesions to brain 1 M.O.

Due to Carcinoma of left kidney Unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Metastatic lesion of skull Date of op. Feb 4 1948

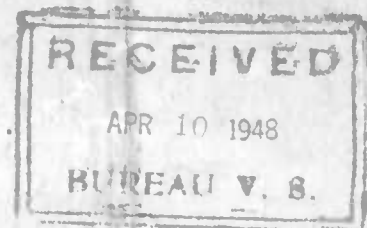
Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE William McLean M. D. or other  
 Address 1801 Eye St NW Wash DC Date signed 4-1-1948

See 0112

Place



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04075 242

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Capitol Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
 City or town Capitol Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6128 Kingston Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Martha Ellen (Ada) Benson

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Benjamin F Benson  
 6. (c) If alive, give age 82 years  
 7. Birth date of deceased (mo., day, yr.) September 12, 1870  
 8. AGE: Years 77 Months Days If less than one day hrs. min.

9. Birthplace Montgomery County, Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Home  
 12. Name George Connor  
 13. Birthplace Maryland  
 14. Maiden name Mrs. Mae Knight  
 15. Birthplace Maryland

16. Informant Mrs. Rose M. Morris  
 Address 6128 Kingston Rd, Capitol Hgts Md  
 17. Burial Date thereof Apr 3, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Adrian Chapel  
 Location Seat Pl. Md.

18. Funeral director W.W. Cohen Bros Co.  
 Address 1400 - Chapin St NW  
April 1, 1948 Carrie F. Campbell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1948 at 7:15 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1947 to April 1, 1948 and that I last saw him alive on March 31, 1948.

## Immediate cause of death

Hypertensive coronary heart disease

## DURATION

8 yearsDue to Diabetes mellitus8 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE William BranninM. D. OFFICIALAddress Capitol Heights Md Date signed 4/1/48

RECEIVED

APR 2 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

### 1. PLACE OF DEATH

County Pr. Geo Co  
City or town Cheverly Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death 18 years

Hospital, institution, or street address where death occurred:

Primer George General Hospital

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo C

City or town 6490 F St N.E  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Maryland Park Md.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Vincent Salvatore Briguglio

### 3. (b) Social Security Number

#### 4. Sex

male

#### 5. Color or race

white

#### 6. (a) Single, married, widowed, or divorced

married

#### 6. (b) Name of husband or wife

Julia Briguglio

#### 7. Birth date of

deceased (mo., day, yr.)

Jan 12 1881

#### 6. (c) If alive, give age

63 years

#### 8. AGE:

Years

Months

Days

If less than one day

67

hrs. min.

#### 9. Birthplace

Italy

(Town, county, and state)

#### 10. Usual occupation

Barber

#### 11. Industry or business

#### FATHER

#### 12. Name

Vincent Salvatore Briguglio

#### 13. Birthplace

Italy

#### MOTHER

#### 14. Maiden name

unknown

#### 15. Birthplace

Italy

#### 16. Informant

Thomas Briguglio

#### Address

606 F St N.E. Wash D.C.

#### 17.

(Burial, cremation, or removal, which?)

#### Date thereof

April 16, 1948

#### Cemetery or crematory

Edgar Hill Cemetery

#### Location

Suitland, Md.

#### 18. Funeral director

Timothy Hanlon

#### Address

641- 11. St N.E. Wash. D.C.

#### 19.

(Date rec'd by registrar)

4/13 1948

Amanda Downey

Registrar

#### 23. SIGNATURE

W. Smit Pitcher M.D.

M. D. or other

#### Address

6906 Ritchie Rd SE

Date signed april 13 1948

### MEDICAL CERTIFICATION

20. DATE OF DEATH april 13 19 48 at 12:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

april 12 19 48 to april 13 19 48

and that I last saw him alive on april 12 19 48

#### Immediate cause of death

Coronary Thrombosis

#### DURATION

15 Hours

Due to

coronary arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

#### Major findings of operations

Date of op.

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

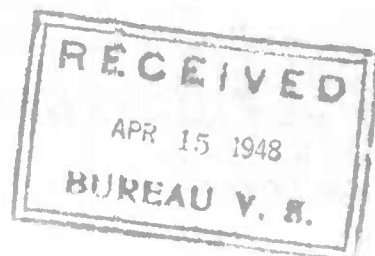
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prima George  
 City or town Riversdale, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 hours  
 Hospital, institution, or street address where death occurred:  
Eugene Leland Memorial Hospital  
 How long in hospital or institution? 19 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey County Union  
 City or town Linden  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1319 North Wood Ave.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war World War I ✓

## 3. (a) FULL NAME

Frederick Anthony Brodesser

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Eleanor Brodesser  
 7. Birth date of deceased (mo., day, yr.) March 18, 1893 6. (c) If alive, give age 44 years  
 8. AGE: Years 55 Months 21 Days 44 If less than one day  
 hrs. min.

9. Birthplace Elizabeth, N. J.  
 (Town, county, and state)  
 10. Usual occupation Real Estate & Insurance  
 11. Industry or business

MOTHER FATHER  
 12. Name Frederick Brodesser  
 13. Birthplace Germany  
 14. Maiden name Rose Rerf  
 15. Birthplace Germany  
 16. Informant Mrs. Eleanor Brodesser  
 Address 1319 North Wood Ave, Linden, N.J.  
 17. Removal Date thereof April 9, 1948  
 (Cause, occasion, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory  
 Location Baltimore, Md.  
 18. Funeral director John A. Moran  
 Address 300 E. Baltimore St. Baltimore Md.  
 19. April 9, 1948 Mrs. Jas. L. Lippert  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1948 at 11 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 8, 1948 to April 8, 1948  
 and that I last saw him alive on April 8, 1948

Immediate cause of death Coronary occlusion  
arteriosclerotic H. Dis.  
 Due to 1 year.

Other conditions  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.

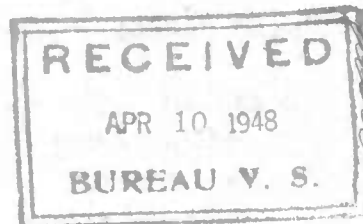
Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  
 Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE L. W. Malin, M.D.  
 M. D. or other  
 Address Riversdale Md. Data signed 4-8-48

Mr. James Senne  
4309 Langatt St.

*Staple*



*Mr.*

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Bladensburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Transient  
 Hospital, institution, or street address where death occurred:  
Kenilworth Ave.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pri. Geo.  
 City or town Brentwood  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4523 - 39th Place  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

RAYMOND LEON BUTLER

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Lenora E. Butler  
 6.(c) If alive, give age 29 years  
 7. Birth date of deceased (mo., day, yr.) May 21, 1914  
 8. AGE: Years 33 Months 10 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Landover, Md.  
 (Town, county, and state)  
 10. Usual occupation Instrument Assembler  
 11. Industry or business U.S. Navy Yard, Wash., D.C.  
 12. Name Richard Butler  
 13. Birthplace Md.  
 14. Maiden name Mary Frances Queen  
 15. Birthplace Maryland

16. Informant Lenora E. Butler  
4523 - 39th pl., Brentwood, Md.  
 17. Removal Date thereof April 2, 1948  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
Stewart Funeral Home  
 Cemetery or crematory 30 H St N E Washington D. C.  
 Location F. Gasch's sons  
 18. Funeral director Hyattsville Maryland,  
 Address 4/2 48  
 19. Amanda Doney  
 (Date rec'd by registrar) (month) (day) (year)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1948  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Hemorrhage and shock  
 Due to Crushed face and skull  
 Due to Crushed chest  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 4-2-48  
 Where did injury occur Bladensburg, Md. (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Home  
 Means of injury Auto in back of house  
 23. SIGNATURE Dr. J. D. Doney M. D. or other \_\_\_\_\_  
 Address Hyattsville Md. Date signed 4-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 5 1948

BUREAU V. S.

Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04079

93d

272

Form No. G 115 MAY 11 1948 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:

County Pr Geo Co  
City or town Forestville Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Five Years  
Hospital, institution, or street address where death occurred:  
8428 Leona St  
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Pr Geo Co  
City or town Forestville Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 8428 Leona St  
(If rural, give LOCATION)  
2.(a) If veteran, name war .....

3. (a) FULL NAME

Georgia Mary Carter

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband Joseph Andrew Carter  
7. Birth date of deceased (mo., day, yr.) Dec 8 1887 6.(c) If alive, give age ..... years  
8. AGE: Years 60 1/2 Months ..... Days ..... If less than one day ..... hrs. .... min.

9. Birthplace Darfield Pa  
(Town, county, or state)  
10. Usual occupation nurse attendant  
11. Industry or business Suit Service  
12. Name Jesse Jay Swan  
13. Birthplace Maine  
14. Maiden name Olga Austin  
15. Birthplace Pa

16. Informant Mrs Myrtle Sorrell  
Address 8370 Leona St, Wash 20 D.C.  
17. Burial Date thereof Apr. 20 1948  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory Cedar Hill  
Location Smithland Md  
18. Funeral director Wm. Lee's Sons Co  
Address 600 4 st. N.E. D.C.  
19. Apr. 27 - 1948 Edna F. Collier  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 19 48 at 7:45 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 15 19 48 to April 27 19 48  
and that I last saw her alive on April 27 19 48  
Immediate cause of death Congestive heart failure  
DURATION 11 day.  
Due to Hypertensive Heart Disease ?  
Due to .....  
Other conditions .....  
(Include pregnancy within 8 months of death)  
Major findings of operations .....  
Date of op. ....  
Autopsy results .....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ..... Date of .....  
Where did injury occur? ..... (City or town) ..... (County) ..... (State) .....  
Injured at home, farm, industry, public place (where?) .....  
Means of injury ..... Injured at work? .....  
23. SIGNATURE W. Suit Patchin M. D. or other  
6906 Patchin Rd SE  
Address Wash 19 D.C. Date signed Apr. 27-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04080

93d

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County...

City or town...

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State...

County...

City or town...

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4107-53 - Ave. 1st St. 1

(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

56

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 14

19 48

at

12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb

19 47

to

April 14

19 48

and that I last saw him alive on

April 13

19 48

Immediate cause of death

Pulmonary

Edema

DURATION

few minutes

Due to

Hypertensive Cardis-

Due to

Vascular disease

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dayton O. Watkins

Address

5306 Annapolis Rd., Annapolis, Md.

Date signed 4-15-48



**RECEIVED**

APR 19 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 239

## 1. PLACE OF DEATH:

County Prince George  
 City or town Laurel  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

Warren's HospitalHow long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County BrooklynCity or town Brooklyn  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 141 Lafayette Avenue  
 (If rural, give LOCATION)2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Charles Boice Chaney

## 3. (b) Social Security Number

None

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

February 7, 1875

8. AGE:

Years

Months

Days

It less than one day

73128

hrs.

min.

9. Birthplace

Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation

Retired machine engineer

11. Industry or business

U.S. Navy Yard

FATHER

12. Name

Charles B. Chaney

MOTHER

13. Birthplace

Baltimore, Maryland

14. Maiden name

Mary E. Boice

15. Birthplace

Strasburg, Virginia

16. Informant

Harry W. Chaney

Address

Laurel, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereat

April 7, 1948  
 (month) (day) (year)

Cemetery or crematory

Landon Park

Location

Baltimore, Maryland

18. Funeral director

W. W. Witherspoon

Address

Laurel, Maryland19. Apr 6

Date rec'd by registrar

19. 48M. Brashear  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4 5 1948, at 1437 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 2 1948, to 4 5 1948

and that I last saw him alive on

Immediate cause of death Central  
hypertension  
deaths  
ischemic

DURATION

3 d.5 1/2 h.3 1/2 h.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

B. B. Warren  
Laurel, Md.Date signed 4 6 48

RECEIVED

APR 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 46d 04082 232

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Rural - Upper Marlboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pr. Geo.  
 City or town Rural - Upper Marlboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4 1/2 east - Rt 301  
 (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Molly Beall Chaney

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female W Married

6. (b) Name of husband or wife William C Chaney7. Birth date of deceased (mo., day, yr.) 1891 8. (c) If alive, give age 65 years

8. AGE: Years 57 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Hom

11. Industry or business

12. Name John C. Shipley13. Birthplace King County, Virginia14. Maiden name Marion C. Shipley15. Birthplace King County, Virginia16. Informant William C ChaneyAddress Upper Marlboro, Md17. (Burial, cremation, or removal. Which?) Burial Date thereof April 20 1948  
(month) (day) (year)Cemetery or crematory St. IgnaceLocation Upper Marlboro, Md19. Funeral director Harry HutchinsonAddress St. Ignace

19. April 19 48 R. B. Smith  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Apr 19 48 at 5:33 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 47 to Apr 16 19 48  
 and that I last saw h. er alive on 16 Apr 48 19 48

Immediate cause of death Carcinoma of rectum

C. metastatic  
 DURATION Wk

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

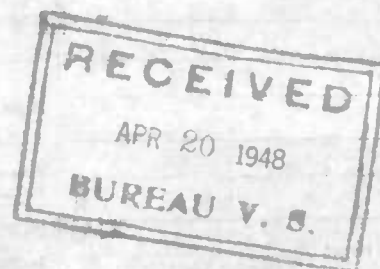
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. B. Smith M. D. or other \_\_\_\_\_Address Upper Marlboro, Md Date signed 17 Apr 48

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ATTORNEY GENERAL



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Brentwood Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Prs Geo.  
 City or town Brentwood Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3401 Taylor st  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war X

## 3. (a) FULL NAME

Alice Genera Chase

## 3. (b) Social Security Number

X

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife Wallace Chase  
 7. Birth date of deceased (mo., day, yr.) Oct 12, 1868 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 79 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington D.C.  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business Housewife12. Name unknown13. Birthplace unknown14. Maiden name Sarah Williams15. Birthplace unknown16. Informant Viola BanfieldAddress Brentwood Md.17. Burial Date thereon April 29, 1948

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory CongressionalLocation Washington D.C.18. Funeral director F. Wacchi's sonsAddress Hyattsville Md.19. April 29 19 48 Mrs. Jas. Severe

(Date rec'd by registrar) (Signature of Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 27 19 48 at 12:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
APRIL 12 19 48 to APRIL 27 19 48  
 and that I last saw him alive on APRIL 27 19 48

Immediate cause of death CORONARY OBSTRUCTION  
 DURATION ?

Due to Generalized Arteriosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE David J. Blayman M.D.Address 4118-30th St. Mt. Rainier Md. Date signed 4/27/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04084

245

## 1. PLACE OF DEATH:

County Prince George's  
City or town Riverdale Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's  
City or town Riverdale  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6029 Baltimore avenue.  
(If rural, give LOCATION)  
World War II

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ruth Kimball Christensen

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife John Christensen7. Birth date of deceased (mo., day, yr.) Dec, 31, 1916- 6.(c) If alive, give age 46 years8. AGE: Years 31 Months Days If less than one day  
.....hrs. ....min.9. Birthplace Maine  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Clarence Kimball  
13. Birthplace Maine14. Maiden name Olivet Mc Clellan  
15. Birthplace Maine16. Informant John Christensen  
Address Riverdale Md.17. Transportation Date thereof April 12, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woodlawn Cemetery  
Location Westbrook Maine18. Funeral director F. Gasch's Sons  
Address Hyattsville Maryland19. April 12, 1948 Mrs. J. J. Severe  
(Date rec'd by registrar) (Signature of Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1948 at 11:15P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death Shock DURATIONDue to Electrocution

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4-10-48Where did injury occur? Riverdale (City or town) Prince George's (County) Md. (State)Injured at home, farm, industry, public place (where?) HomeMedical history Up on electric chair in bath tub23. SIGNATURE James M. D. or otherAddress Hyattsville Md. Date signed 4-11-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

APR 14 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 mos., 13 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 3 mos., 13 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 1505 Vermont Avenue, N. W.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war.....

## 3. (a) FULL NAME

FRANCES COLE

## 3. (b) Social Security Number

---

4. Sex..... Female  
 5. Color or race..... Negro  
 6. (a) Single, married, widowed, or divorced..... Separated  
 6. (b) Name of husband or wife..... Sandy Cole  
 6. (c) If alive, give age..... 25 years  
 7. Birth date of deceased (mo., day, yr.) March 13, 1925  
 8. AGE: Years Months Days If less than one day  
 23 23 1 14 hrs. min.

9. Birthplace..... Winston Salem, North Carolina  
 (Town, county, and state)  
 10. Usual occupation..... Fountain Service  
 11. Industry or business.....

FATHER  
 12. Name..... Arthur Wright  
 13. Birthplace..... Richmond, Virginia  
 14. Maiden name..... Hattie Smith  
 15. Birthplace..... North Carolina  
 MOTHER

16. Informant..... Deceased  
 Address.....  
 17. Removal..... Date thereof..... Apr 28, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....  
 Location..... to Washington, D. C.  
 18. Funeral director..... Johnson & Jenkins  
 Address..... 2053 Georgia Ave. N. W.  
 19. Apr 28, 1948 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Apr 27, 1948 at 5:45 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13, 1948, to Apr 27, 1948  
 and that I last saw him alive on Apr 26, 1948

Immediate cause of death..... Pulmonary Tuberculosis  
 DURATION..... 6 mo.

Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?  
 23. SIGNATURE..... Daniel Leo Pinneane M.D.  
 Address..... Glenn Dale, Md. Date signed..... 4/27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 5 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH: Prince Georges  
County.....  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 11 mos.  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 11 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 506 Eye Street, N. W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

LEWIS COMPOMIZZI

### 3. (b) Social Security Number

579-03-2683

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Dominica Compomizzi  
6.(c) If alive, give age - years  
7. Birth date of deceased (mo., day, yr.) April 24, 1894  
8. AGE: Years Months Days If less than one day  
53 53 11 28 hrs. min.  
9. Birthplace Italy  
(Town, county, and state)  
10. Usual occupation Watchman  
11. Industry or business - - -

12. Name Costanzo Compomizzi  
13. Birthplace Italy  
14. Maiden name Guiseppia Donofrio  
15. Birthplace Italy

16. Informant Deceased  
Address

17. removal Date thereof Apr. 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Washington  
Location D. C.

18. Funeral director W. W. Chambers Co.  
Address 517 - 11th St. S. E. Washington D. C.

19. 4 - 22 - 19 48 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 21, 1948 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on May 20, 1947 to Apr. 21, 1948 and that I last saw him alive on Apr. 21, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 5 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

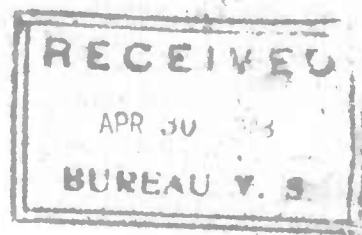
23. SIGNATURE Daniel Leo Pincus MD M. D. or other

Address Glen Dale Md Date signed 4/21/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04087

93d

Reg. Dist. No. *245*

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Riverdale  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 daysHospital, institution, or street address where death occurred:  
Eugene Leland Memorial HospitalHow long in hospital or institution? 20 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4208 Queensbury Road  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mrs. Ethel - Cookman

## 3. (b) Social Security Number

?

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Widowed</u>

6. (b) Name of husband or wife William Abner Cookman

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) September 10, 1884

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>7</u>	<u>15</u>	.....hrs. ....min.

9. Birthplace New Jersey  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Lewis Smith Paxton13. Birthplace New Jersey14. Maiden name Carrie Hartman Rockhill15. Birthplace New Jersey16. Informant Hospital recordsAddress transportation April 27, 1948

17. (Burial, cremation, or removal. Which Date thereof (month) (day) (year)

Cemetery or crematory Bordentown CemeteryLocation Bordentown N.J.18. Funeral director F. Pasche SonzAddress Hyattsville Md.19. April 26, 1948 Mrs. Jas. Severe(Date rec'd by registrar) Neighborhood Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 19 48 at 10:18 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 19 48 to April 25 19 48 and that I last saw him alive on April 24 19 48Immediate cause of death Cerebral hemorrhage DURATION suddenDue to arteriosclerotic heart disease 10 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Recharffubry, M.D. M. D. or otherAddress 4208 Queensbury Road Riverdale, Maryland Date signed 4-25-48



RECEIVED

APR 29 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:  
County Prince George's  
City or town Oxon Hill  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Transient  
Hospital, institution, or street address where death occurred:  
near 5120 St. Barnabas Rd.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Oxon Hill  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. near 5120 St. Barnabas Rd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3.(a) FULL NAME

Raymond Edward Counts

### 3.(b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 27, 1940

8. AGE: Years 7 Months Days If less than one day hrs. min.

9. Birthplace Washington, D.C.  
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

12. Name Bruce R. Counts

13. Birthplace Jefferson City, Tenn.

14. Maiden name Edna I. Lowe

15. Birthplace Washington, D.C.

16. Informant Bruce R. Counts

Address 5120 St. Barnabas Rd. Oxon Hill, Md.

17. Burial Date thereof May 3, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forestville Cemetery

Location Forestville Md

18. Funeral director F. Pascha sons

Address Forestville Md.

19. 5/3/48 (Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1948 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Hemorrhage and shock

Due to Crushed skull

Fractured left arm

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/30/48

Where did injury occur? Oxon Hill P. G. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) St. Barnabas Rd.

Means of injury On bicycle struck by a truck Injured at work No

Deputy Medical Examiner

23. SIGNATURE [Signature] M. or other

Address Forestville, Md. Date signed 5/1/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04089

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 month  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution?..... 1 month

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 903 R. Street, N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

LEROY CRAWFORD.

## 3. (b) Social Security Number

242-10-4455

4. Sex..... Male  
 5. Color or race..... Negro  
 6. (a) Single, married, widowed, or divorced..... Married  
 6. (b) Name of husband or wife..... Awatha Crawford  
 7. Birth date of deceased (mo., day, yr.)..... August 1, 1912  
 6. (c) If alive, give age..... 29 years  
 8. AGE: Years..... 35 Months..... 35 Days..... 8  
 If less than one day..... hrs. .... min.  
 9. Birthplace..... Goldsboro, North Carolina  
 (Town, county, and state)  
 10. Usual occupation..... Baker  
 11. Industry or business.....  
 12. Name..... Willis Crawford  
 13. Birthplace..... ? North Carolina  
 14. Maiden name..... Laurena Coley  
 15. Birthplace..... ? North Carolina

16. Informant..... Deceased  
 Address.....  
 17. Removal to Wash. D.C. Date thereof..... 4 7 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....  
 Location..... The burial Goldsboro, North Carolina  
 18. Funeral director..... Carter Memorial  
 Address..... 29 H St. N.W.  
 19. Apr 7 19 48 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Apr. 6 19 48 at 10:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 Mar 5, 19 48, to Apr. 6, 19 48  
 and that I last saw him alive on Apr. 6, 19 48.

Immediate cause of death..... Pulmonary Tuberculosis  
 DURATION..... 2 1/2 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

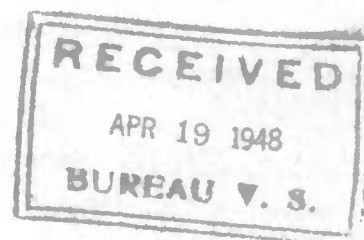
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Pinecone M.D.  
 M. D. or other

Address..... Glen Dale Md. Date signed..... 4/6/48.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince George's  
City or town Chesapeake, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 hr 15 min  
Hospital, institution, or street address where death occurred:  
Prince George's Hosp. 1st  
How long in hospital or institution? 1 hr 15 min

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Chesapeake  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5900 Benning Road  
(If rural, give LOCATION)  
2. (a) If veteran, name war.....

### 3. (a) FULL NAME

Russell Dant

### 3. (b) Social Security Number

4. Sex m 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife father - Russell Dant

7. Birth date of deceased (mo., day, yr.) January 10 1948 6. (c) If alive, give age..... years

8. AGE: Years 3 Months 29 Days day If less than one day..... hrs. .... min.

9. Birthplace Prince George's  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Russell Dant

13. Birthplace M.C.

14. Maiden name Mary Evelyn Dennis

15. Birthplace Arkansas

16. Informant father

Address 5900 Benning Road

Benning, Md.

17. (Burial, cremation, or removal, Which?) Burial Date thereof April 10, 1948

Cemetery or crematory Sedan Hill

Location Sydney, Md.

18. Funeral director Robert H. Matthews

Address 131-112nd St. Wash. D.C.

19. 4/9 19 48 Amanda H. Hovary Registrar

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 48 at 12:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 19 48 to April 8 19 48 and that I last saw him alive on April 8 19 48

Immediate cause of death Gastroenteritis  
Anhydremia  
Due to anhydremia

Due to.....

Other conditions Prematurity

(Include pregnancy within 8 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ararou Dant, M.D. M. D. or other

Address 4314 Gallatin St. Date signed 4/9/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 10 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04091 225

1. PLACE OF DEATH  
County Prince George  
City or town Mt Rainier  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md. County Prince George  
City or town Mt Rainier  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4007 - 33 St. N.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3.(a) FULL NAME Thomas H Ector

3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced W

6.(b) Name of husband or wife Kate Ector

7. Birth date of deceased (mo., day, yr.) Sept 18 1869 6.(c) If alive, give age years

8. AGE: Years 77 Months 7 Days 9 It less than one day hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation retired - Business

11. Industry or business U.S. Govt.

12. Name Wm Ector

13. Birthplace Maryland

14. Maiden name Jane Hines

15. Birthplace Calvert F. Ector Md.

16. Informant Burial Address 4007 - 33 St

17. (Burial, cremation, or removal) Which? Burial Date thereof April 23 1948  
(month) (day) (year)

Cemetery or crematory Cons. Memorial

Location 1 Wm. Lee's Sons Co

18. Funeral director 300 - 4 St. N.E. D.C. Address 4/20 1948  
(Date rec'd by registrar)

MEDICAL CERTIFICATION  
20. DATE OF DEATH APRIL 20 1948 at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19 1948 to APRIL 20 1948  
and that I last saw him alive on APRIL 20 1948

Immediate cause of death Congestive Heart Failure

Due to

Due to

Other conditions DRAINING KIDNEY SINUS (rt)

CIRCULATORY COLLAPSE

SEVERE ANEMIA  
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

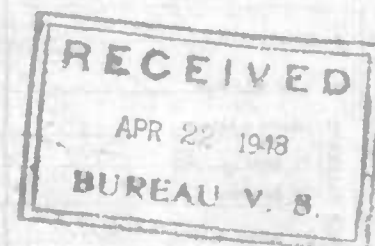
23. SIGNATURE David J. Blayman, M.D.  
Address 4118 - 30th St - Mt Rainier Date signed 4/20/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04092  
245

## 1. PLACE OF DEATH:

County Prince George Rural  
 City or town Quantico  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 1/2 mo  
 Hospital, institution, or street address where death occurred:  
Molten James Rest Home  
 How long in hospital or institution? 2 1/2 mo.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD. County Prince George  
 City or town Farmville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Della Fowler

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Sydney Walter Fowler 6. (c) If alive, give age 66 years  
 7. Birth date of deceased (mo., day, yr.) March 17, 1881

8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs \_\_\_\_\_ min.

9. Birthplace Brandywine Md  
 (Town, county, and state)

10. Usual occupation housewife

## 11. Industry or business

12. Name Frank Bryant  
 13. Birthplace Bowil Md  
 14. Maiden name cora ogle  
 15. Birthplace Md

16. Informant Sydney Fowler  
 Address upper marlboro Md

17. (Burial, cremation, or removal, Which?) Burial Date thereof Apr 26, 1948  
 (month) (day) (year)  
 Cemetery or crematory Croom

Location Maryland  
 18. Funeral director Ritchie Bros  
 Address upper marlboro Md

19. Date rec'd by registrar April 26 1948 James Cery Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 23, 1948 at 10:25 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 7, 1947 to Apr 23, 1948  
 and that I last saw him alive on Apr 23, 1948.

## Immediate cause of death

Cerebral Hemorrhage

## DURATION

2 days

Due to Gen ArteriosclerosisDue to hypertension

3 yrs

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Edward L. Moore MD M. D. or other  
28 Capitol Ave  
Takoma Park Md Address \_\_\_\_\_ Date signed 4/23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

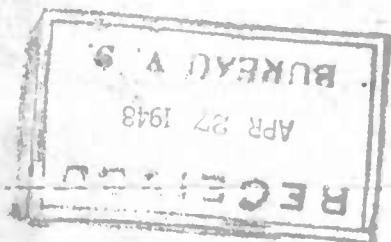
VS A15

9.45-15M

(1)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
is especially important.



*Delivered to Mr. Richter*

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

### 1. PLACE OF DEATH:

County Prince Geo  
City or town No District  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 40 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Prince Geo  
City or town No District  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 45-39 Banner St  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Jacob Hoy

### 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced married

8.(b) Name of husband or wife Mabel Hoy

7. Birth date of deceased (mo., day, yr.) April 8, 1868 6.(c) If alive, give age, years 18

8. AGE: Years 80 Months 01 Days 18 It less than one day hrs. min.

9. Birthplace Delaware, Wilmington  
(Town, county, and state)

10. Usual occupation Retired (plumber)

11. Industry or business

12. Name

13. Birthplace W. Brown

14. Maiden name

15. Birthplace

16. Informant Mabel Fox

Address 4539 Banner St

17. Removal Date thereof April 8, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington D.C.

Location 1432 You St NW D.C.

18. Funeral director W. E. G. Jarvis & Co

Address 1432 You St NW D.C.

19. April 8, 1948 Mrs. Jas. Lawrence  
(Date read by registrar) (Signature of Registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1948 19 48, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Nov 18, 1947  
and that I last saw him alive on Nov 18, 1947

Immediate cause of death Heart failure DURATION

Due to coronary hour

Due to high blood pressure 10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE W. S. Hudson, M.D.

Address Laurel, Md Date signed 4-8-48

*Handwritten notes in the top left corner, including "No. 10" and "March 1948".*

*Handwritten signature or initials in the top right corner.*

RECEIVED  
APR 10 1948  
BUREAU V. S.

*Handwritten notes below the stamp, including "March 1948".*

*Handwritten notes at the bottom right, including "March 1948".*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04094

Reg. Dist. No. 243

1. PLACE OF DEATH:  
Prince Georges

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Md. County..... Pri. Geo.

City or town..... Bowie (Rural)  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

AUBREY LINWOOD GARY, SR.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Emma Ruth Gary

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1895

8. AGE: Years 52 Months Days If less than one day hrs. min.

9. Birthplace Virginia  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Unknown

13. Birthplace " Va.?

14. Maiden name "

15. Birthplace " Va. ?

16. Informant Aubrey Linwood Gary, Jr.

Address Bowie, Md.

17. Burial Date thereof Apr 28 1948

(Burial, cremation, or removal) Which?

Cemetery or crematory near George Washington

Location near Baltimore Md

18. Funeral director H. G. Gasky Sons

Address 1844 Leadenburg Rd

19. April 19 1948 Amos H. Dornay

(Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948 at 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 16 1948 to Apr 16 1948

and that I last saw him/her on Apr 16 1948

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Warren M.D.

Address Laurel Date signed 4/17/48

RECEIVED

APR 24 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04095

93d

Reg. Dist. No. ....

1. PLACE OF DEATH: Prince George  
 County.....  
 City or town.....Riversdale, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 hours.  
 Hospital, institution, or street address where death occurred:  
Island Memorial Hosp -  
 How long in hospital or institution? 17 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....Md. County.....Pr. George  
 City or town.....Mt. Rainier  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....4118-30th St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
Julius Goldman

3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Widowed  
 6.(b) Name of husband or wife.....Rose Goldman  
 (deceased)  
 7. Birth date of deceased (mo., day, yr.).....August 7, 1872 6.(c) If alive, give age..... years  
 8. AGE: Years.....75 Months.....8 Days.....— If less than one day..... hrs. .... min.

9. Birthplace.....Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation.....Retired  
 11. Industry or business.....  
 12. Name.....Samuel Goldman  
 13. Birthplace.....Europe  
 14. Maiden name.....Sarah  
 15. Birthplace.....Europe

16. Informant.....Mrs. Bertha Shugar (daughter)  
 Address.....4118-30th St. Mt. Rainier, Md.  
 17. Burial.....Burial Date thereof.....4-9-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or place of burial.....Hebrew Friendship Cem  
 Location.....Jack Lewis, Inc  
 18. Funeral director.....2100 Eutaw Place  
 Address.....  
 19. April 7, 1948 A.W. Hebrich  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....April 7, 1948 5<sup>30</sup> P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 6, 1948 to April 7, 1948  
 and that I last saw him alive on April 7, 1948

Immediate cause of death.....Cerebral Thrombosis DURATION.....4 wks.

Due to.....

Due to.....

Other conditions.....Anemia - Kidneys shut down ?  
Cardiovascular collapse  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE.....S. A. Blayman Md  
 M. D. or other.....  
 Address.....4118-30th St, Mt. Rainier, Md. Date signed.....4/7/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04096

FILM No. G 115 APR 23 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George's  
City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 16 days  
Hospital, institution, or street address where death occurred:  
Prince Georges General Hosp.  
How long in hospital or institution? 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Washington, DC County \_\_\_\_\_  
City or town \_\_\_\_\_  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6761 Central Ave. S.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war. \_\_\_\_\_

## 3. (a) FULL NAME

Bertha B. Grimes

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife ASA I. Grimes  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) 11-29-1894  
8. AGE: Years 53 Months 3 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Dedham, Mass.  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business \_\_\_\_\_  
12. Name Michael McSorley  
13. Birthplace Boston, Mass.  
14. Maiden name Eleanor Jane McDonald  
15. Birthplace Nova Scotia, Canada

16. Informant \_\_\_\_\_  
Address Burial  
17. (Burial, cremation, or removal. Which?) Burial Date thereof 4/21/48  
(month) (day) (year)  
Cemetery or crematory Belington National Cem  
Location Belington, Va  
18. Funeral director W.W. Chambers Co.  
Address 517-112 St SE  
4/19 19 48 Amanda Dourney  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 19 48, at 3:33 P. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 47, to April 18 19 48,  
and that I last saw him alive on April 18 19 48.  
Immediate cause of death Carcinoma of Cervix  
DURATION 1 year  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Reo-terico vaginal fistula  
(Include pregnancy within 8 months of death)  
Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_  
Autopsy results same  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William Brannin M. D. 4/18/48  
Address Capitol Heights, Md Date signed 4/18/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince Georges  
City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 hours

Hospital, institution, or street address where death occurred:

Prince Georges Hosp  
How long in hospital or institution? 19 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State md County Prince Georges

City or town Colman Manor  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3310 - 40th Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Boby Boy Gundersheimer

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) APRIL 23, 1948  
6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

19hrs.25min.

## 9. Birthplace

Cheverly, Prince Geo. Co.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

Eugene Gundersheimer

## 13. Birthplace

Wash D.C.

## MOTHER

## 14. Maiden name

Helen Zeets

## 15. Birthplace

Pitts Burg, Pa

## 16. Informant

mo. Rev

## Address

3310 - 40th Ave. Colman

## 17.

(Burial, cremation, or removal, Which?)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

## Date thereof

(month) (day) (year)

Prince Georges General HospitalCheverly, MdA.R. Beasley, Supt.Cheverly, Md.4/28 48 Amanda Downey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 April 19 48 at 3:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 19 48 to April 24 19 48  
and that I last saw him alive on April 24 19 48

Immediate cause of death

Pneumonia

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

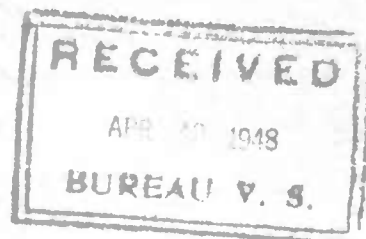
Injured at work?

## 23. SIGNATURE

Ronald V. Fleschman

M. D. or other

Address 3801 - 35th Ave. Hyattsville Date signed 4-24-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Manassas  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

13 and O Carbon tracks

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Bowie  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Fred JOSEPH HAKER

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) JUNE 30, 1914

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

33927

hrs.

min.

9. Birthplace BOWIE ROAD, PRINCE GEORGES CO., LAUREL, MD.  
(Town, county, and state)10. Usual occupation U.S. DEPT. AGRICULTURE - FARM EMPLOYEE11. Industry or business PLANT INDUSTRY STATION

## FATHER

12. Name HENRY A. HAKER13. Birthplace HOWARD COUNTY, Md.

## MOTHER

14. Maiden name ELIZABETH OTTEN15. Birthplace HOWARD COUNTY, Md.

## 16. Informant

Address LAUREL, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

April 29, 1948  
(month) (day) (year)

Cemetery or crematory

ST. MARY'S CHURCH CEMETERY

Location

8th ST. LAUREL, Md.

## 18. Funeral director

Address 505 Washington Blvd., Laurel, Md.

19. (Date rec'd by registrar)

19

48 M. Brashear

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1948 at 1:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19

Immediate cause of death

Hemorrhage and shock

DURATION

Due to multiple crushing injuries to body

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4-27-48Where did injury occur? Manassas (City or town) (County) (State)Injured at home, farm, industry, public place (where?) 13 + O tracksMeans of injury struck by a train Injured at work? noSignature James T. V. Jones M. D. or otherAddress 7 West 11th St. Date signed 4-27-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04099

Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 11 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 11 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1416 Morse Street, N. E.  
(If rural, give LOCATION)  
2. (a) If veteran, name war.....

### 3. (a) FULL NAME

HARDING, LORMAN

### 3. (b) Social Security Number

- - -

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Gertrude Curtis Harding  
6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 1, 1885

8. AGE: Years Months Days If less than one day  
62 62 10 3  
..... hrs. .... min.

9. Birthplace Fredericksburg, Virginia  
(Town, county, and state)

10. Usual occupation Public Librarian

11. Industry or business - - -

FATHER 12. Name Thadeus Harding

13. Birthplace Fredericksburg, Virginia

MOTHER 14. Maiden name Frances Sullivan

15. Birthplace Fredericksburg, Virginia

18. Informant Gertrude Harding, Wife

Address 1416 Morse Street, N. E.

17. Removal to church, D.C. Date thereof April 4 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Timothy Hanlon

Address 641 24th St. N.E. (RRA)

18. Apr. 4, 1948. Rowland S. Phillips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/23 1948 to 4/4 1948  
and that I last saw him alive on 4/4/48 19

Immediate cause of death pulmonary tuberculosis DURATION 2 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Lee Pincus M.D.

M. D. or other

Address Glen Dale, Md. Date signed 4/4/48

MARGIN RESERVED FOR BINDING

VS A151 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 10 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04160

159

245

### 1. PLACE OF DEATH:

County Prince George's County  
City or town Riverdale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 22 days  
Hospital, institution, or street address where death occurred:  
Deland Memorial Hospital  
How long in hospital or institution? 22 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Hyattsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5009 56th Ave.  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

ALAN RALPH

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single married, widowed, or divorced Single

### 6. (b) Name of husband or wife

### 7. Birth date of deceased (mo., day, yr.)

March 31, 1948

### 6. (c) If alive, give age \_\_\_\_\_ years

### 8. AGE:

Years

Months

Days

If less than one day

22

hrs.

min.

### 9. Birthplace

Riverdale, Maryland  
(Town, county, and state)

### 10. Usual occupation

### 11. Industry or business

FATHER

### 12. Name

Ralph Waldo Harper

### 13. Birthplace

Franklin, West Virginia

MOTHER

### 14. Maiden name

Lathrop, E. L. Snodgrass, Harper

### 15. Birthplace

Laytonville, Maryland

### 16. Informant

Father

### Address

5009 56th Ave. Hyattsville Md

### 17. Burial

(Burial, cremation, or removal, Which?)

### Date thereof

April 23, 1948

### Cemetery or crematory

Evergreen

### Location

Bethensburg Md

### 18. Funeral director

### Address

F. Paschall sons  
Hyattsville Md.

### 19. Date rec'd by registrar

April 24

### 19

James Berry

Registrar

### MEDICAL CERTIFICATION

### 20. DATE OF DEATH

Apr 22

19

48

at

7

o

5

PM

### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 31

19

48

to

Apr 22

19

48

PM

### and that I last saw him alive on

Apr 22

19

48

PM

### Immediate cause of death

Immaturity  
(Born at 7 1/2 months gestation)

### DURATION

22 days

### Due to

### Due to

### Other conditions

(Include pregnancy within 8 months of death)

### Major findings of operations

Date of op.

### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

### 23. SIGNATURE

L. W. Malin

M. D. or other

Address

Riverdale, Md

Date signed

4-22-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 26 1948

BUREAU V. S.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 142

## 1. PLACE OF DEATH:

County Penn. George  
 City or town Hilliards  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 years  
 Hospital, institution, or street address where death occurred:  
1217-49th Ave.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Penn. George  
 City or town Hilliards  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1217-49th Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Hannah Jane Hudson

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Charles Robert Hudson  
 6.(c) If alive, give age 83 years  
 7. Birth date of deceased (mo., day, yr.) May 12, 1873  
 8. AGE: Years 74 Months — Days — It less than one day — hrs. — min.

9. Birthplace Markham Township, Ontario Canada  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Home  
 12. Name Joseph Wideman  
 13. Birthplace Ontario Canada  
 14. Maiden name Annie Margaret (last name unknown)  
 15. Birthplace

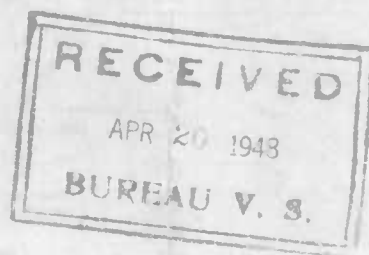
16. Informant Chas Robert Hudson  
 Address 1217-49th Ave, Hilliards, Md  
 17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof APRIL 19 1948  
 (month) (day) (year)  
 Cemetery or crematory CEDAR HILL CEMETERY  
 Location WASHINGTON, D.C.  
 18. Funeral director Martin W. Hypond, Co  
 Address 1300-N. N.W. Wash. D.C.  
 19. April 16 1948 Carin E Campbell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 19 48 at 3:00 M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 19 48 to April 15 19 48  
 and that I last saw him alive on April 15 19 48  
 Immediate cause of death arteriosclerosis with  
arteriosclerotic heart disease  
 DURATION 15 years  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  
 Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE William Brannin M. D. or other  
 Address Capital Heights, Md Date signed 4/15/48

I



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04102

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 11 mos., 1 day  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 Now long in hospital or institution?..... 11 mos., 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. #7 Logan Court, N. W.  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war..... ✓

## 3. (a) FULL NAME

EMMIE MOORE JACKSON

## 3. (b) Social Security Number

- - -

4. Sex..... Female  
 5. Color or race..... Negro  
 6.(a) Single, married, widowed, or divorced..... Separated  
 6.(b) Name of husband or wife..... Curtis Jackson  
 6.(c) if alive, give age..... 43 years  
 7. Birth date of deceased (mo., day, yr.)..... June 2, 1902  
 8. AGE: Years Months Days If less than one day  
 45 45 10 14 ..... hrs. .... min.

9. Birthplace..... Salters, North Carolina  
 (Town, county, and state)  
 10. Usual occupation..... Housewife  
 11. Industry or business..... -  
 12. Name..... Benjamin Moore  
 13. Birthplace..... Salters, North Carolina  
 14. Maiden name..... Nettie Godson  
 15. Birthplace..... Salters, North Carolina

16. Informant..... Deceased  
 Address.....  
 17. Burial Date thereof..... April 23 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... Cemetery  
 Location..... Salters, North Carolina  
 18. Funeral director..... Stewart's Funeral Home  
 Address..... #30 "H" St. N.E. Wash, D.C.  
 19. 4/17 1948 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Apr. 16, 1948, at 6:20 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14, 1947, to Apr. 16, 1948, and that I last saw him alive on Apr. 16, 1948.  
 Immediate cause of death..... Pulmonary Tuberculosis  
 DURATION..... 1 yr  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)  
 Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?  
 23. SIGNATURE..... Daniel Leo Pineane M.D.  
 M. D. or other  
 Address..... Glenn Dale, Md. Date signed..... 4/16/48

RECEIVED

APR 24 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04103

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Pro Georges Co.  
 City or town Cheverly Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N. C. County \_\_\_\_\_

City or town Charlotte  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1915 Providence Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

David B. Kanoy Sr.

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Eileen Kanoy

7. Birth date of

deceased (mo., day, yr.)

Sept 10, 1894

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

53

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace High Point, N. C.

(Town, county, and state)

10. Usual occupation

President11. Industry or business Kanoy Machine Works

FATHER

12. Name

William Kanoy

13. Birthplace

North Carolina

MOTHER

14. Maiden name

McLend

15. Birthplace

North Carolina

18. Informant

David B. Kanoy Jr.

Address

Charlotte, N. C.17. removal

(Burial, cremation, or removal, Which?)

Date thereof April 30, 1948

(month) (day) (year)

Cemetery or crematory

Charlotte

Location

North Carolina

18. Funeral director

M. Gasch's Sons

Address

Hyattsville Maryland.

19.

(Date rec'd by registrar)

19.

48

Amanda Seurey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1948 at 832P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

and that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

Coronary Occlusion

DURATION

Underlying cause:Cardiovascular renal disease

Due to

Due to

Other conditions The automobile that he was riding in was in a accident at the time the attack took place  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner

23. SIGNATURE

James J. Boyd

M. D. or other

Address

Date signed

Forestville, Md. 4/28/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This certificate is especially important. Physicians please write the causes of death clearly and legibly.

From letter from Dr. Boyd: "I think that the underlying cause of his death was the cardio vascular renal disease. Whether the coronary occlusion was precipitated by the accident and a possible cardiovascular response to danger or was coincidental I cannot say. The facts are as stated above. I think if the accident had not occurred he would not have had the occlusion at that moment." ams. 6-2-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 mos., 4 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 5 mos., 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 923 - 9th St., N. E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Israel Kaufman

## 3. (b) Social Security Number

- - -

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Hannah Kaufman

6. (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) June 25, 1875

8. AGE:	Years	Months	Days	If less than one day
72	72	9	15	.....hrs. ....min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation Retired Watchman

11. Industry or business - - -

12. Name Bernard Kaufman

13. Birthplace Russia

14. Maiden name Margaret Tistry

15. Birthplace Russia

16. Informant Deceased

Address

17. Removal to Wash. D. C. Date thereof 4 9 48 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director B. Dargatzis &amp; Son

Address 3501 - 14th St. N.W. Wash. D. C.

19. 4/9 48 Roseland S. Phillips Registrar (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948 at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 1947 to Apr 9 1948 and that I last saw him alive on Apr 4 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 5 months

Due to

Ous to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane MD M. D. or other

Address Glen Dale Md. Date signed 4/9/48

RECEIVED

APR 24 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

04105

## 1. PLACE OF DEATH:

County Prince Georges

City or town Washington Heights  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:  
4807 - W Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Washington Heights  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4807 - W Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Albertus Ketchum

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Hattie Ketchum

7. Birth date of deceased (mo., day, yr.) August 15, 1876

8. AGE: Years 71 Months Days If less than one day  
hrs. min.9. Birthplace Pennsylvania  
(Town, county, and state)

10. Usual occupation Engineer

11. Industry or business Rail Road

12. Name Isaac Ketchum

13. Birthplace Pennsylvania

14. Maiden name Jane Cleveland

15. Birthplace Pennsylvania

16. Informant Hattie Ketchum

Address 4807 - W Street Brooklyn

17. Burial Date thereof April 21, 1948  
(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location Washington D.C.

18. Funeral director J. H. Chambers

Address 517 11th St. S.E. Wash., D.C.

19. April 18, 1948 Carrie F. Campbell  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1948, at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death Coronary occlusion

Due to Cardiovascular

Disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

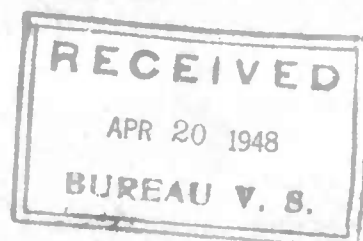
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Respectfully medical Examiner

23. SIGNATURE Marshall Ketchum M.D. or other

Address Washington D.C. Date signed April 18, 1948



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04106

## CERTIFICATE OF DEATH

Reg. Dist. No. 23.1

### 1. PLACE OF DEATH:

County Prince George's

City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days 6 hrs.

Hospital, institution, or street address where death occurred:  
Prince George's General Hospital

How long in hospital or institution? 18 days 6 hrs.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Cottage City  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4004 - Bladensburg Rd  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Nena Alberta Kleh

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Fem. W. M.

6. (b) Name of husband Thomas Kleh

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1893

8. AGE: Years Months Days If less than one day  
54 7 27 hrs. min.

9. Birthplace Virginia  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Bay ce

13. Birthplace Va

14. Maiden name Clark

15. Birthplace Va

16. Informant Thomas R. Kleh

Address 4004 Bladensburg Rd Cottage City Md

17. Burial, cremation, or removal. Which? Burial Date thereof 4/30-48  
(month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Wash DC.

18. Funeral director New G Harlicks Co

Address Trinidad - Md

19. 4/30 48 Amanda Dorney  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27 19 48 at 11:05 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 47 to 4-27 19 48

and that I last saw her alive on 4-27 19 48

Immediate cause of death Acute pulmonary embolism DURATION 3 hrs.

assoc. E

Due to Myelitis, etiology unknown 8 mos

Due to

Other conditions Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J Murphy, MD M. D. or other

Address 2014 R St NW, DC Date signed 4, 24 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0410231  
245

## 1. PLACE OF DEATH:

County Prince George's  
City or town Hyattsville Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Prs Geo

City or town Hyattsville Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4003 Oglethorpe St  
(If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (a) FULL NAME

Sallie Ione Koonce

## 3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife George W. Koonce6. (c) If alive, give age 77 years7. Birth date of deceased (mo., day, yr.) August 22, 18698. AGE: Years 78 Months - Days - If less than one dayhrs. - min. -9. Birthplace Illinois  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John T. Buchanan13. Birthplace Illinois14. Maiden name Elizabeth Mattingly15. Birthplace Illinois16. Informant George W. KoonceAddress Hyattsville Md.17. Transportation Date thereof April 14, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GreenviewLocation Illinois18. Funeral director J. Gucci's sonsAddress Hyattsville Md.19. 4/15 48 Amanda Dourney  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1948 at 8:15 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1947 to April 14, 1948and that I last saw him alive on April 14, 1948

Immediate cause of death

Coronary Atherosclerosis

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

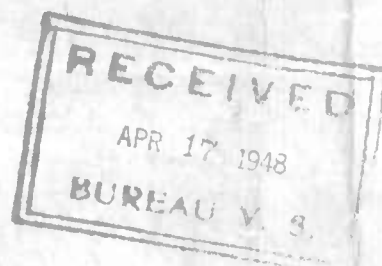
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Deitz, M.D.Address Hyattsville Md. Date signed 4-15-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04108 106

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Accokeek  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 21 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince GeorgeCity or town Accokeek  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Jacob Luther Watson Kremer

## 3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Elizabeth M. Kremer.7. Birth date of deceased (mo., day, yr.) Sept. 22. 1873. 6.(c) If alive, give age 68 years8. AGE: Years 74 Months 6 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Lebanon Church, Va.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Own Farm.12. Name Wm. Kremer13. Birthplace Winchester, Va.14. Maiden name Not known15. Birthplace Highland County, Va.16. Informant Floyd KremerAddress Accokeek R. Rd.17. Burial Date thereof April 10, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lebanon Church CemeteryLocation " " Va.18. Funeral director Hunt & MydyAddress Wd Port. Rd.19. 4-8 48 M L Mowbr  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 8 19 48 at 3 05 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 19 48 to April 8 19 48 and that I last saw him alive on April 7 19 48Immediate cause of death Cerebral Hemorrhage DURATION 6 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank Susan L.S. M. D. or otherAddress Indian Head Rd Date signed 4-8-48

RECEIVED

APR 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04110

242

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Coral Hills  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

FRANK JOSEPH LOCKBOEHLER

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Minnie Lockboehler7. Birth date of deceased (mo., day, yr.) Jan 17, 18648. AGE: Years 79 Months 7 Days 1 If less than one day hrs. min.9. Birthplace Washington D.C.  
(Town, county, and state)10. Usual occupation Houseman - Retired11. Industry or business U. S. Navy Yard12. Name Nicholas Lockboehler13. Birthplace Germany14. Maiden name Caroline Reutell15. Birthplace Germany16. Informant Minnie LockboehlerAddress 5209 - P. St. Coral Hills Md.17. Burial Date thereof April 16, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director J. William Peis for CoAddress 300 - 4th St. N. E. Washington, D.C.19. Apr. 14 48 Carrie J. Campbell  
(Date rec'd by registrar) (year) (signature)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Coral Hills  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5209 P. St.  
(If rural, give LOCATION)2. (a) If veteran, name war Spanish American

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 19 48 at 2:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 48 to April 14 19 48.and that I last saw him alive on April 13 19 48.Immediate cause of death Carcinoma (hemorrhagic) of lung

## DURATION

2-3 years?

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Brannin M. D. deanAddress Capitol Hgts, Md. Date signed 4/14/48

RECEIVED

APR 15 1943

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04109

Reg. Dist. No. 230

1. PLACE OF DEATH:  
County Prince George's  
City or town Berwyn  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Transient  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County  
City or town Berwyn  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Under  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3.(a) FULL NAME

William Lopez

### 3.(b) Social Security Number

578-20-2095

4. Sex Male 5. Color or race Colored 6.(a) Single, married, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1908 6.(c) If alive, give age years

8. AGE: Years about 40 Months Days It less than one day hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial Date thereof April 22, 1948  
(Burial, cremation, or removal, which?) (month, day, year)

Cemetery or crematory Methodist Cemetery

Location Bladensburg Md

18. Funeral director F. Gasche sonz

Address Hyattsville Md

19. 4/22 1948 Amenda Drouney  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948 at 7:40 p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Hemorrhage and shock DURATION

Due to Fracture of the base of the skull

Fracture of the pelvis

Due to Fracture of both femurs

Compound fracture of both legs

six inches above ankles

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/16/48

Where did injury occur? Berwyn P. G. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route # 1

Means of injury Pedestrian struck by an auto.

Deputy Medical Examiner

23. SIGNATURE James S. V. St. John M.D. or other

Address Forestville, Md. Date signed 4/16/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

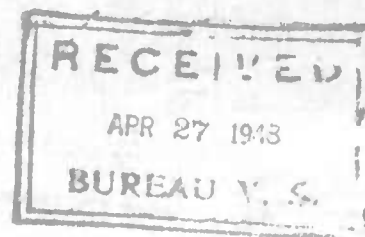
RECEIVED

NAVY

NAVY

NAVY

NAVY



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 041280

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Beltsville Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 76 years  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
City or town Beltsville Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Russell Magruder

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Madge M. Magruder  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) December 13, 1871.  
8. AGE: Years 76 Months 4 Days 0 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Beltsville Maryland  
(Town, county, and state)  
10. Usual occupation farmer  
11. Industry or business

12. Name Fielder Magruder  
13. Birthplace Maryland  
14. Maiden name Mary Ann Cummings  
15. Birthplace Baltimore Maryland

16. Informant Mrs Madge Mason Magruder  
Address Beltsville Md.

17. Burial Date thereon April 16, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory St. John's Cemetery  
Beltsville Maryland  
Location

18. Funeral director F. Gasch's Sons  
Address Hyattsville Maryland.

19. April 16th 1948 John D. Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1948 19. \_\_\_\_\_ at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 19. 48 to April 13 19. 48  
and that I last saw him alive on April 13, 1948 19. \_\_\_\_\_

Immediate cause of death Chronic Myocarditis  
Due to Arterio-sclerosis  
Due to Smoking  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. Allen G. Pitt M. D. or other \_\_\_\_\_  
Address Berwyn, Md Date signed 4/13/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 17 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 234

## 1. PLACE OF DEATH:

County ~~MONTGOMERY~~ Prince GeorgesCity or town SUITLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 MONTHS

Hospital, institution, or street address where death occurred:

SONS HOMEHow long in hospital or institution? -----

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ARKANSAS County SEBASTIANCity or town FORT SMITH.  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. #1, FREE FERRY DRIVE  
(If rural, give LOCATION)2.(a) If veteran, name war SPANISH WAR. ✓

## 3.(a) FULL NAME

ROBERT GRAY MEDLIN.

## 3.(b) Social Security Number

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6.(a) Single, married, widowed, or divorced

WIDOWED.6.(b) Name of ~~husband~~ or wife ANNIE BRONTE7. Birth date of deceased (mo., day, yr.) APRIL 1, 18766.(c) If alive, give age --- years

## 8. AGE:

Years

Months

Days

If less than one day

72017--- hrs. --- min.9. Birthplace BROWNSVILLE, TENNESSEE.  
(Town, county, and state)

## 10. Usual occupation

RETIRED

## 11. Industry or business

FATHER 12. Name ROBERT MEDLIN.13. Birthplace UNKNOWN. U.S.A.MOTHER 14. Maiden name CANNOT BE LEARNED.15. Birthplace UNKNOWN. U.S.A.16. Informant Will C. Medlin. Son.Address 745 S. 23<sup>RD</sup>. ST. ARLINGTON, VA.17. BURIAL Date thereof APRIL 21, 1948.  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory NATIONAL CEMETERYLocation FORT SMITH, ARKANSAS18. Funeral director Halter E. FitzgeraldAddress Arlington, Virginia.19. April 17, 1948 Arnold L. Beall  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 17, 19 48. at --- M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16, 1948 to April 16, 1948  
and that I last saw him alive on April 16, 1948

## Immediate cause of death

Arteriosclerotic Heart disease

## DURATION

4.5 yr.Due to Generalized arteriosclerosis

Due to

Other conditions Rheumatoid arthritis15 yr.

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ---

Means of injury

Injured at work?

23. SIGNATURE Frank S. Pellegrini M. D. or otherAddress 3409 Alab. Av., N.E. Date signed 4-17-48

RECEIVED

MAY 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04113 239

## 1. PLACE OF DEATH

County Prince George'sCity or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since April 29 1945 - 3 yrs

Hospital, institution, or street address where death occurred:

Laurel SanitariumHow long in hospital or institution? 3 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 211 E. MAIN ST

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

EDWARDMINOR

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

N

6. (a) Single, married, widowed, or divorced

Widower

8. (b) Name of husband or wife

C. ANNA MINORNEE DUCKETT

(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

March 14 1858

8. AGE:

90

Years

1

Months

Days

5

If less than one day

6

hrs.

15

9. Birthplace

Richmond Co. Virginia

(Town, county, and state)

10. Usual occupation

Minister - Baptist

11. Industry or business

FATHER

12. Name

Minor, Raulen

13. Birthplace

Richmond Co. Virginia

MOTHER

14. Maiden name

Moody, Malissa

15. Birthplace

Virginia

16. Informant

Dr. J. C. Coggin

Address

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

4/23/48

(month) (day) (year)

Cemetery or crematory

LOUDON PK.

Location

BALTO. MD.

18. Funeral director

WM. T. TICKNER & SONS

Address

BALTO. MD.19. April 2219 48

(Date rec'd by registrar)

C. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948 at 5:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 29 1945 to April 20 1948and that I last saw him alive on April 20 1948

Immediate cause of death

Myocardial failure

DURATION

6 weeks

Due to

Senility

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jesse C. Coggin

M. D. or other

Address Laurel Sanitarium Laurel Date signed Apr. 20 1948



MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE CITY OF BOSTON

RECEIVED

RECEIVED  
APR 13 1948  
BUREAU V. S.

42-8-4  
APR 13 1948

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **04115**  
**242**

### 1. PLACE OF DEATH:

County **Prince Georges**  
City or town **Lees Pleasant**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **7 years**  
Hospital, institution, or street address where death occurred:  
**7801 - Walker Mill Road**  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State **Maryland** County **Prince Georges**  
City or town **Lees Pleasant**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **7801 - Walker Mill Road**  
(If rural, give LOCATION)  
2.(a) if veteran, name war

### 3. (a) FULL NAME

**Virgie L. Mauch**

### 3. (b) Social Security Number

4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Single**

### 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) **May 2, 1891** 6. (c) If alive, give age years

8. AGE: Years **56** Months Days If less than one day hrs. min.

9. Birthplace **Virginia**  
(Town, county, and state)

10. Usual occupation **House work**

### 11. Industry or business

12. Name **Ira Mauch**

13. Birthplace **Virginia**

14. Maiden name **Phoebe Ann Shenk**

15. Birthplace **Virginia**

16. Informant **Mrs. Claude Smith**

Address **Luray, Va**

17. **Burial** Date thereof **April 18, 1948**  
(Burial, cremation, or removal. Which?) (month) (day) (year)

### Cemetery or crematory

Location **Luray, Virginia**

18. Funeral director **Jess. F. Birch's Sons**

Address **3034 - M St., N.W. - Wash., D.C.**

19. **April 16** 19 **48** **Carrie F. Campbell**  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH **April 15, 1948** 10<sup>30</sup> P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h. alive on 19

Immediate cause of death **Congestive heart failure**

Due to **Cardiovascular disease**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Carrie F. Campbell** M. D. or other

Address **Freshwater, Md** Date signed **4-15-48**

MARGIN RESERVED FOR BINDING

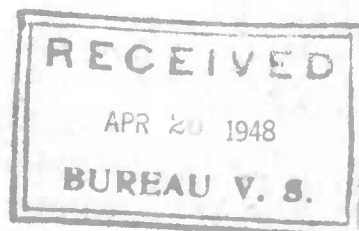
9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Mrs Campbell  
406-61 ave



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Chesley  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 hours  
Hospital, institution, or street address where death occurred:  
Prince Georges Hosp.  
How long in hospital or institution? 10 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Prince Georges  
City or town Calmar Manor  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3415 - 39th Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Myers, M - Myron

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Pauline Bell

7. Birth date of deceased (mo., day, yr.) July 15, 1875 6. (c) If alive, give age years

8. AGE: Years 72 Months Days If less than one day  
hrs. min.

9. Birthplace New York  
(City, town, county, and state)

10. Usual occupation Retired Accountant

11. Industry or business

12. Name Myers

13. Birthplace N.Y.

14. Maiden name Minnie C. Hayes

15. Birthplace N.Y.

16. Informant Mrs. Pauline Bell Myers

Address 3415 - 39th Ave.

17. Bureau Date thereof 4/14/1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Burlington National Va.

Location Virginia

18. Funeral director The S.H. Hines Co.

Address 2901 - 14th St. NW

19. 4/12/48 Amanda Downey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 11 April 19 48 at 9:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 48 to April 11 19 48

and that I last saw him alive on April 11 19 48

Immediate cause of death Myocardial Infarction

Due to Ventricular Fibrillation

Acute and Chronic Coronary

Insufficiency

Due to Hypertensive Heart Disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Benjamin S. Miller M.D.

Address 3824 - 34th St. Mt. Rainier Date signed April 11 1948

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor age is especially important. Physicians: please write the causes of death clearly and legibly.



**RECEIVED**

APR 14 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2-45

## 1. PLACE OF DEATH:

County Pune George  
 City or town Hyattsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md. County Pune George  
 City or town Hyattsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5221-42 Marl  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Charles David Ogle

## 3.(b) Social Security Number

705-10-2511

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mary Maselung

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1893

8. AGE: Years 64 Months 6 Days 18 If less than one day

9. Birthplace Fredrick Co. Md.  
 (Town, county, and state)

10. Usual occupation Ticket Agent

11. Industry or business B&O Railroad

12. Name John Ogle

13. Birthplace Fredrick Co. Md.

14. Maiden name Rebecca Maselung

15. Birthplace Fredrick Co. Md.

16. Informant Mrs. Chas. D. Ogle

Address 5221 42nd place, Hyattsville, Md.

17. Burial, cremation, or removal, which? Burial Date thereof Apr. 17, 1948

Cemetery or crematory St. Charles Cem.

Location Fredrick Md.

18. Funeral director H. B. Etchum & Son

Address Fredrick, Md.

19. April 15, 1948 Mrs. Jas. Severe

(Date rec'd by registrar) (Signature of Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1948 at 7:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Apr 15, 1948

and that I last saw him alive on April 15, 1948

Immediate cause of death Myocarditis

Due to Hypertension

Other conditions

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Leonard Hays

Address Hyattsville, Md. Date signed 4-15-48

(Signature of Physician)

RECEIVED

APR 16 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

04117

### 1. PLACE OF DEATH:

County Prince George's  
City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 1/2 hours  
Hospital, institution, or street address where death occurred:  
Prince George's General Hospital  
How long in hospital or institution? 4 1/2 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Mitchelville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

J. Franklin Peach

### 3. (b) Social Security Number

4. Sex Male 5. Color or race w 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) 7-9-1875 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 72 Months 9 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Dr. John Peach

13. Birthplace md.

14. Maiden name Caroline Hamilton

15. Birthplace md.

16. Informant Herndon Peach

Address Mitchelville, Md.

17. Burial Date thereof April 7, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt. Oak

Location Mitchelville, Md.

18. Funeral director Clarence Foreacre

Address Mitchelville, Md.

19. 4/5 1948 Amanda Deoney  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1948 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1948 to April 4 1948 and that I last saw him alive on April 4 1948

Immediate cause of death Coronary Thrombosis DURATION 2 days

Due to Arteriosclerosis 10 yrs

Due to \_\_\_\_\_

Other conditions Secondary Anemia 6 months

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James F. Sarscer M. D. or other \_\_\_\_\_

Address Upper Marlboro, Md. Date signed 4-4-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 6 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04118  
Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 yr., 9 mos., 29 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 1 yr., 9 mos., 29 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 947 Rhode Island Avenue, N. W.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

MARY F. PEOPLES

### 3. (b) Social Security Number

- - -

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female

Negro

Separated

6.(b) Name of husband or wife Fred Peoples

6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) September 22, 1918

8. AGE: Years Months Days If less than one day  
29 29 7 5 hrs. min.

9. Birthplace Newberry, South Carolina  
(Town, county, and state)

10. Usual occupation Maid

11. Industry or business -

12. Name George W. Baxter

13. Birthplace Newberry, South Carolina

14. Maiden name Anna J. Richardson

15. Birthplace Newberry, South Carolina

16. Informant Deceased

Address

17. Removal Date thereof Apr. 27, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory

Location to Washington, D.C.

18. Funeral director A. Ernest Harris Co.

Address 1432 1/2 St. N.W. Wash. D.C.

19. Apr. 27, 1948 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 27, 1948, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28, 1946, to Apr. 27, 1948, and that I last saw her alive on Apr. 26, 1948.

Immediate cause of death Pulmonary Tuberculosis

DURATION

2 yrs 11 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Glen Dale Md. Date signed 4/27/48

MARGIN RESERVED FOR BINDING

1

9-45-15M

VS A151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 5 1916

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Sunnybrook  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
5500 Elden Road  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Sunnybrook  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5500 Elden Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3.(a) FULL NAME

David T. Thompson Porterfield

### 3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Feb 17, 1934  
8. AGE: Years 14 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Grove City Pa  
(Town, county, and state)  
10. Usual occupation Student  
11. Industry or business  
12. Name Claryl J. Porterfield  
13. Birthplace Emelton Pa  
14. Maiden name Alma Thompson  
15. Birthplace Grove City Pa

16. Informant Claryl J. Porterfield  
Address Sunnybrook, Md.  
17. Burial Date thereof April 24, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory St. Lincoln  
Location Washington D.C.  
18. Funeral director F. Kasch's Sons  
Address Hyattsville Md.  
19. April 23, 1948 Amarda Downey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1948 at 9:55 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_,  
and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_\_,  
Immediate cause of death Asphyxiation  
Due to Hanging  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

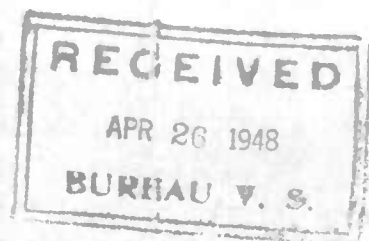
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide suicide Date of 4-21-48  
Where did injury occur? Sunnybrook P.O. Md  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) Home  
Means of injury hanged self Injured at work?  
Deputy medical examiner  
23. SIGNATURE James D. Foster M. D. or other  
Address Freshville Md Date signed 4-23-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





Reg. Dist. No. 272

1. PLACE OF DEATH:

County Prince George  
City or town Tamper Hill, Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15 yrs  
Hospital, institution, or street address where death occurred:  
none  
How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Prince George  
City or town Temple Hill Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4935 Temple Hill Wood SE  
(If rural, give LOCATION)  
2. (a) If veteran, name war World war #1 US Marine

**3. (a) FULL NAME**

Albert Prevost.

**3. (b) Social Security Number**

none

4. Sex M	5. Color or race W.	6. (a) Single, married, widowed, or divorced Married
-------------	------------------------	---

6.(b) Name of husband or wife Julia Kareba Prevost

7. Birth date of deceased (mo., day, yr.) *Sept 18 1882* 6. (c) If alive, give age *63* years

8. AGE:	Years	Months	Days	If less than one day
	65			..... hrs. .... mi

9. Birthplace. Washington, DC  
(Town, county, and state)

10. Usual occupation... *former or Captain's helper*

11. Industry or business U.S. Government

12. Name Albert Prevost

13. Birthplace France

14. Maiden name. Rosea Williamson  
15. Birthplace Maryland.

16. Informant Julia E. Prevost.

Address Temple Hills Road, Washington, D.C.  
Bureau Apr 30/48

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/1/68 (month) (day) (year)  
 Cemetery or place of interment Beverly Hills

Location Switzerland, N.Y.

18. Funeral director: W W Chambers Co

Address 517 1/2 N 16th St.  
Chil 13 48 Carr 7 Can 1 Ball

19 April 11 19 90  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948 at 3<sup>30</sup> A

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from April 16 1948 to April 17 1948

and that I last saw him alive on April 16 1948

Immediate cause of death ..... Carcinoma of .....  
.....  
.....

DURATION ..... 5-240 .....

Prostate  
metastases

.....

San Juan, Pinar del Rio

Other conditions: None

(Include pregnancy within 2 months of death)

Major findings of operations.....

.....Date of op. ....

.....

Autopsy results.....

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide..... Date of .....

Injured at home, farm, industry, public place (where?) Chavez

Means of Injury	Injured at work?
22	

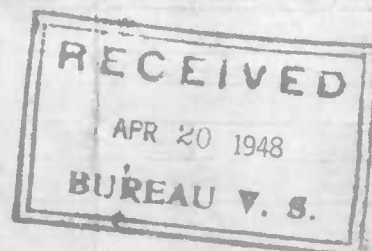
23. SIGNATURE: Paul C Van Yatta M.D. 2/10/00

Address Washington 19 DC Date signed April 17 1948

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 20 1948

BUREAU V. S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County W. George  
Village or City Chidmore

Registration Dist. No. 04121  
242

No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## 2. FULL NAME

Judith Lynn Guzenbergy If U. S. Veteran, specify WAR \_\_\_\_\_

(a) Residence: Marine Home for Retarded Children Ward Quarters 2312-9 Quantico, Virginia  
(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Feb 17, 1947

7. AGE Years 1 Months 2 Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Quantico, Va  
(State or country)

FATHER

13. NAME Harry Guzenbergy

14. BIRTHPLACE (city or town) San Antonio, Tex  
(State or country)

MOTHER

15. MAIDEN NAME Campbell J. Gistrup

16. BIRTHPLACE (city or town) Richmond, Va  
(State or country)

17. INFORMANT Mrs. Mammie  
(Address) Chidmore

18. BURIAL, CREMATION, OR REMOVAL Burial  
Place Richmond Va. Date 4-19-, 1948

19. UNDERTAKER The S. H. Hines Co.  
(Address) 2901 - 14th St N.W.

20. FILED 4/17, 1948 Amanda Deoney  
Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April 17, 1948  
(Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from Sept 3<sup>rd</sup>, 1947, to April 17, 1948

I last saw her alive on April 16, 1948; death is held to have occurred on the date stated above, at 7:45 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Ac. Catarrhal Fever

Congenital heart

Date of onset

1 wks ago

birth

Other Contributory Cause of Importance:

It has had a marked respiratory difficulty since birth

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of Injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) John J. Maloney M. D.

(Address) Cherry Hill, Md

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
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## Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04122

6

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Chesapeake  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Death on arrival  
 Hospital, institution, or street address where death occurred:  
Prince Georges General Hospital  
 How long in hospital or institution? 2

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George's  
 City or town St. Painsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3307 St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Russell Samuel Quinn

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife <u>Mildred E. Quinn</u>		
7. Birth date of deceased (mo., day, yr.) <u>March 8, 1908</u>		
8. AGE: Years <u>40</u> Months _____ Days _____ It less than one day _____ hrs. _____ min.		
9. Birthplace <u>Pennsylvania</u> (Town, county and state)		
10. Usual occupation <u>Line man</u>		
11. Industry or business <u>Pennsylvania P. R.</u>		
FATHER	12. Name <u>John Arthur Quinn</u>	
	13. Birthplace <u>Indiana</u>	
MOTHER	14. Maiden name <u>Elizabeth Brown</u>	
	15. Birthplace <u>Pennsylvania</u>	
16. Informant <u>Mr. Mildred E. Quinn</u> Address <u>3307 - St. Painsville, Md.</u>		
17. <u>Burial</u> Date thereof <u>4-8-48</u> (Burial, cremation, or removal, Which?) (month) (day) (year)		
Cemetery or crematory <u>F. B. Lincoln</u>		
Location <u>Wash - Balto. Blvd + D. C. Line</u>		
18. Funeral director <u>Wm. J. Galley</u> Address <u>3200 R. I. Ave. St. Painsville Md.</u>		
19. <u>4/7</u> 19 <u>48</u> <u>Amanda Downey</u> (Date rec'd by registrar) Registrar		

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1948 at 2:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_ and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Due to Cardiovascular renal disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

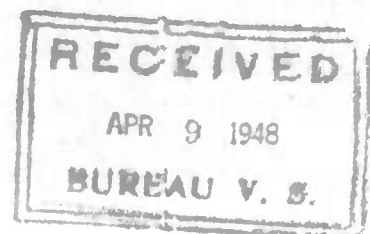
Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
Deputy Medical Examiner

23. SIGNATURE James D. V. Jones M.D. or other \_\_\_\_\_  
 Address Freshville Md Date signed 4-5-48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04123

Reg. Dist. No. 242

### 1. PLACE OF DEATH:

County PRINCE GEORGE'S  
City or town CAPITAL HEIGHTS  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution:  
6121-C-STREET  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) 22 YEARS

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MARYLAND County PRINCE GEORGES  
City or town CAPITAL HEIGHTS Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 6121-C-STREET  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

MYRA LUCRETIA READ

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED

6 (b) Name of husband or wife CARL EDWIN READ

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) JANUARY 5, 1882

8. AGE: Years Months Days If less than one day  
66 3 15 hrs. min.

9. Birthplace GERMAN, NEW YORK  
(Town, county, and state)

10. Usual occupation HOUSEWIFE

### 11. Industry or business

12. Name CHARLES CLINTON

13. Birthplace NEW YORK.

14. Maiden name EMMA FOSGATE

15. Birthplace NEW YORK

16. Informant CARL EDWIN READ

Address 6121-C-ST, CAPITOL HEIGHTS, MD.

17. BURIAL Date thereof APRIL 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MAPLE GROVE

Location SMITHVILLE FLATS, NEW YORK.

18. Funeral director Harry L. Slye

Address 1009-H-ST, N.W. - WASHINGTON, D.C.

19. Apr 21 - 1948 E. F. Collins  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 20, 1948 at 7:48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1948 to April 20, 1948 and that I last saw him alive on April 19, 1948.

Immediate cause of death

DURATION

Intia Cranial Hemorrhage 5 days  
Due to cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE James D. Boyd D. or other  
Address Freshkills Rd Date signed 4-20-48

MARGIN RESERVED FOR BINDING

VSAT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Mrs. Edna Collins  
2400 Marlboro Pike

RECEIVED  
MAY 1 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04124

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George'sCity or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

Prince Georges General HospitalHow long in hospital or institution? 9 days

## 3. (a) FULL NAME

Henry J. Ritterbusch

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married widowed

6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

7. Birth date of

deceased (mo., day, yr.)

2-13-1861

8. AGE:

Years

Months

Days

If less than one day

8722

.....hrs.

.....min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Henry

13. Birthplace

Baltimore

MOTHER

14. Maiden name

Elsbeth

15. Birthplace

Not Known

16. Informant

Mrs. Margaret Edg

Address

Riverdale Md

17.

(Burial, cremation, or removal, which?)

Date thereof

4/22/48  
(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

7225 Eastern ave

18. Funeral director

Blumen F. Hoffmann

Address

1639 Broadway

19.

(Date rec'd by registrar)

19

48A. W. Hebrink

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Prince Georges

City or town

Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4607 - Riverdale Rd

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 19 48 at 10 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 19 48 to April 18 19 48and that I last saw him alive on April 17 19 48

Immediate cause of death

Pneumonia

DURATION

9 days

Due to

Due to

Other conditions

Cerebral arteriosclerosis  
Generalized arteriosclerosis  
(Include pregnancy within 3 months of death)Years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Carolyn Deitz, M.D.  
per Dr. Deitz

M. D. or other

Address

4314 Gallatin StDate signed 4/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The form is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04125

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County... Prince Georges  
 City or town... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year, 26 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 1 year, 26 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D. C. County...  
 City or town... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 1319 Pennsylvania Avenue, S. E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... ✓

## 3. (a) FULL NAME

SAMUEL ROBERT

## 3. (b) Social Security Number

577-26-7552

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife - - -  
 6.(c) If alive, give age - years  
 7. Birth date of deceased (mo., day, yr.) October 10, 1900  
 8. AGE: Years Months Days If less than one day  
 47 47 6 14 hrs. min.

9. Birthplace... Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation... Sheetmetal Worker  
 11. Industry or business - - -  
 12. Name... William P. Robert  
 13. Birthplace... Washington, D. C.  
 14. Maiden name... Sarah Kavanaugh  
 15. Birthplace... Ireland

16. Informant... Deceased  
 Address...  
 17. Removal... Date thereof... April 25, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory...  
 Location... Washington, D. C.  
 18. Funeral director... Timothy Hannon Funeral Home  
 Address... 641-H St. N.E., Wash., D. C.  
 19. Apr. 25, 1948 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 24 1948 at 7<sup>15</sup> P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1948 to April 24 1948  
 and that I last saw him alive on April 24 1948

Immediate cause of death... Pulmonary Tuberculosis  
 DURATION... 5 yrs 9 mos  
 Due to...  
 Due to...  
 Other conditions...  
 (Include pregnancy within 3 months of death)

Major findings of operations...  
 Date of op...  
 Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE... Daniel Red Pinecone MD  
 M. D. or other  
 Address... Glenn Dale, Md Date signed 4/24/48

RECEIVED

APR 30 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Arlington  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2.3 hrs  
Hospital, institution, or street address where death occurred:  
Leland Memorial Hospital  
How long in hospital or institution? 2.3 hrs.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Prince Georges  
City or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4006 Longfellow St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war name

### 3.(a) FULL NAME

Fred Morgan Lawin

### 3.(b) Social Security Number

214-07-0437

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced Widower  
6.(b) Name of husband or wife Kathleen Hubbard Lawin  
6.(c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) Feb. 4 - 1878  
8. AGE: Years 70 Months 2 Days 26 If less than one day hrs. min.

9. Birthplace Winchendon, Mass.  
(Town, county, and state)  
10. Usual occupation Mechanical Eng.  
11. Industry or business  
12. Name Charles Lawin  
13. Birthplace Montague, Mass.  
14. Maiden name Kathleen Morse  
15. Birthplace

16. Informant Mrs. Margaret Burton  
Address 4006 Longfellow St Hyattsville  
17. Burial Date thereof May 3, 1948  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory St. Lincoln  
Location Washington, DC  
18. Funeral director F. Buckhinson  
Address Hyattsville, Md.  
19. May 3, 1948 Mrs. Jas. Severa  
(Date rec'd by Registrar) (Registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1948 at 10:45 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27, 1948 to April 30, 1948  
and that I last saw him alive on April 30, 1948  
Immediate cause of death Chronic congestive heart failure  
DUE TO arteriosclerosis heart disease  
DUE TO bronchial asthma  
Other conditions 10 yrs.  
(Include pregnancy within 3 months of death)

Major findings of operations 5 yrs.  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

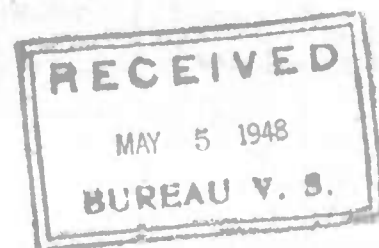
23. SIGNATURE St. P. Schorffenberg, Jr. M.D.  
Address 4404 Leesburg Rd, Rindale Date signed May 1, 1948  
M.D. or other

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04127  
243

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 mos., 9 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 3 mos., 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 221 R. Street, N. E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

ELIZA BELLE SCOTT

## 3. (b) Social Security Number

- - -

4. Sex Female 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Separated  
 6.(b) Name of husband or wife Sabbie Scott  
 6.(c) If alive, give age 45 years  
 7. Birth date of deceased (mo., day, yr.) March 5, 1906  
 8. AGE: Years 42 Months 42 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Hookerton, North Carolina  
 (Town, county, and state)  
 10. Usual occupation Domestic  
 11. Industry or business \_\_\_\_\_  
 12. Name Theophilus Hooker  
 13. Birthplace Hookerton, North Carolina  
 14. Maiden name Mamie Dixon  
 15. Birthplace Hookerton, North Carolina

16. Informant Deceased  
 Address \_\_\_\_\_  
 17. removal Date thereof Apr. 17, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Washington, D. C.  
 Location R. N. Horton  
 Address 1322 - W. St. N.W., Washington D.C.  
 18. Funeral director Rowland S. Phillips  
 Address 4-17-1948  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 16, 1948, at 7:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6, 1948 to Apr. 16, 1948  
 and that I last saw her alive on Apr. 16, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 5 mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinicane MD M. D. or other \_\_\_\_\_Address Glenn Dale, Md. Date signed 4/16/48

RECEIVED

APR 24 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04128 239  
Reg. Dist. No.

1. PLACE OF DEATH:  
County Prince George's County  
City or town Laurel Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 days  
Hospital, institution, or street address where death occurred:  
Harriet's Hospital  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland - County Prince Geo. Co.  
City or town Laurel - Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME  
Bertha M. Sellers

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife George T. Sellers  
7. Birth date of deceased (mo., day, yr.) 1874 6. (c) If alive, give age years  
8. AGE: Years 74 Months 5 Days 5 It less than one day hrs. min.

9. Birthplace Barto - County - Md.  
(Town, county and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Louis Seibel

13. Birthplace Barto - Md.

14. Maiden name Martha E. Makins

15. Birthplace Barto Co - Md.

16. Informant Geo. T. Sellers

Address Laurel - Md - R.F.D. #1

17. Burial, cremation, or removal, Which? Burial Date thereof Apr - 9 - 1948  
(month) (day) (year)

Cemetery or crematory Union Cemetery

Location Buxtonville - Md.

18. Funeral director J. M. Wagon

Address 565 - 7th St. Laurel

19. Date rec'd by registrar Apr 8 48 Registrar M. Brachman

### MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 7 19 48 at 7<sup>25</sup> A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 2 19 48 to Apr 7 19 48

and that I last saw her alive on Apr 7 19 48

Immediate cause of death Myocardial infarction DURATION 4 days

Hypertensive Cardio- 1.8 gm

Vascular disease 1.8 gm

Due to Hypertension

Due to

Other conditions Terminal pneumonia 2 day

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Wagon M.D. or other

Address Laurel Md Date signed 4/8/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly

**RECEIVED**

APR 10 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 mos., 6 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 2 mos., 6 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D. C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 107 D. Street, N. W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

LEROY SIMMONS

### 3. (b) Social Security Number

230-09-3494

4. Sex Male 5. Color or race Negro 8.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mamie Simmons

6.(c) If alive, give age 46 years  
7. Birth date of deceased (mo., day, yr.) March 6, 1902

8. AGE: Years 46 Months 1 Days 14 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Dale, South Carolina  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business ---

FATHER 12. Name Jake Simmons  
13. Birthplace South Carolina

MOTHER 14. Maiden name Emma Stoney  
15. Birthplace South Carolina

16. Informant Deceased

Address \_\_\_\_\_

17. Removal Date thereof April 20 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location \_\_\_\_\_

18. Funeral director Frazier Funeral Home

Address 389 Rhode Island Ave N.W. Wash. D.C.

19. Apr 20 1948 Registrar Rowland S. Phillips  
(Date filed by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948 at 3:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 13 1948 to April 20 1948 and that I last saw him alive on April 19 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 5 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinician M.D. M. D. or other \_\_\_\_\_

Address Glenn Dale Md. Date signed April 20 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

170C

04130

Reg. Dist. No. 234

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Siloesa  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yearsHospital, institution, or street address where death occurred:  
8191 Livingston Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Siloesa  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8191 - Livingston Road  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Rose Mary Thorne

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 30, 19388. AGE: Years 10 Months 10 Days 10 If less than one day hrs. min.9. Birthplace Washington DC  
(Town, county, and state)10. Usual occupation Student

11. Industry or business

12. Name William Thorne13. Birthplace Maryland14. Maiden name Lease Hamilton15. Birthplace Washington DC16. Informant William ThorneAddress 8191 - Livingston Road Siloesa17. Burial Date thereof April 17, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation Maryland18. Funeral director Arthur E. SimmonsAddress 2017 - Nicholas Ave S.E.19. April 5, 1948 19 48 Edward J. Beal  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1948 at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48 to 19 48and that I last saw him alive on 19 48

Immediate cause of death

Due to Memorhage and shockDue to fracture of base of skullDue to Crushed chest

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4-5-48Where did injury occur? Siloesa (City or town) P. Geo (County) MD (State)Injured at home, farm, industry, public place, (when) at homeMeans of injury Electricity (Cause of death)Report made by Dr. J. V. Beal23. SIGNATURE Dr. J. V. Beal M. D. or otherAddress Freestall Way Date signed 4-5-48

RECEIVED

APR 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

04131

## 1. PLACE OF DEATH:

County Prince George's  
City or town Columbia, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred:  
Cosmopolitan Hotel, Columbia, Md.

How long in hospital or institution?

## 3. (a) FULL NAME

John Toliver

Sex Male Color or race White (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 24, 1865  
6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 83 Months 9 Days 26 Less than one day 20 hrs. 20 min.

9. Birthplace KENTUCKY  
(Town, county, and state)

10. Usual occupation LABOR

11. Industry or business

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_

14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_

16. Informant BETH, BENNY F.  
Address 6620 MARLBORO PIKE

17. Removal Date thereof Apr. 21-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_  
Location Washington D.C.

18. Funeral director Martin W. Syong Co.  
Address 1300 N. ST. NW, WASHINGTON

19. Apr. 21 1948 Carrie F. Campbell  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)  
State Maryland County Prince George's  
City or town Columbia, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Cosmopolitan Hotel, Columbia, Md.  
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1948 1948 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14, 1948 to April 21, 1948  
and that I last saw him alive on April 1, 1948

Immediate cause of death Cardio-renal disease  
Pneumonia  
Due to Pulmonary Embolism 24h.  
DURATION 1450.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE \_\_\_\_\_  
M. D. or other \_\_\_\_\_  
Date signed \_\_\_\_\_

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*Handwritten notes, possibly a list or address, mostly illegible due to fading.*

*Handwritten notes, possibly a list or address, mostly illegible due to fading.*

RECEIVED  
APR 23 1948  
BUREAU V. 5.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

157a

04132

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Mt. Rainier  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 weeks  
 Hospital, institution, or street address where death occurred:  
 3209 Perry Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4020 24th Place N.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Stephen Treadway

## 3. (b) Social Security Number

4. Sex male  
 5. Color or race white  
 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) Feb 10, 1948  
 8. AGE: Years Months Days If less than one day  
 1 26 hrs. min.

9. Birthplace Washington D.C.  
 (Town, county, and state)  
 10. Usual occupation house  
 11. Industry or business

12. Name Joseph P. Treadway  
 13. Birthplace District of Columbia  
 14. Maiden name Virginia Winkler  
 15. Birthplace Pennsylvania

16. Informant Joseph P. Treadway  
 Address 4020 24th Place N.E., Washington  
 17. Burial, cremation, or removal, Which? Burial Date thereof 4-6-48  
 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery  
 Location Wash. D.C.  
 18. Funeral director W.W. Chambers & Co.  
 Address Rindall Road

19. Apr. 6 19 48 James Revere  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948 at 9:45 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19  
 and that I last saw him alive on 19

Immediate cause of death Exhaustion  
 Due to Spina Bifida and hydrocephalus  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:  
 Accident, suicide, or homicide  
 Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE James D. Taylor M.D. or other  
 Address Forest Hills Md Date signed 4-5-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 1312  
 04133 2485  
 Reg. Dist. No.

## 1. PLACE OF DEATH:

County Pr. Geo. Co.City or town Mr. Rainier  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pr Geo. Co.City or town Mr. Rainier  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3203 Perry St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Nellie May Truett

## 3. (b) Social Security Number

4. Sex F5. Color or race W6.(a) Single, married, widowed, or divorced widow6.(b) Name of husband or wife Robert F. Truett7. Birth date of deceased (mo., day, yr.) Jan 8 - 18688. AGE: Years 80 Months 0 Days 0 If less than one day9. Birthplace Washington D.C.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Metcalf13. Birthplace Wash. D.C.14. Maiden name unknown15. Birthplace Wash. D.C.16. Informant J.W. StewartAddress 3821 Smith St Arl Va17. Burial Date thereof 4-29-48  
(Burial, cremation, or removal. Which) (Month) (day) (year)Cemetery or crematory Arld. Natl CemLocation Arld. Va18. Funeral director W.W. G. HumesAddress Rivendale - Md19. April 28 1948 James Serry Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26 1948 at 8 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1948 to April 26 1948and that I last saw him alive on April 23 1948Immediate cause of death Chronic Hypertension DURATIONDue to arteriosclerosisDue to hypertensionOther conditions Coronary Artery Disease

(Include pregnancies within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert F. Truett M.D. or otherAddress 3821 Smith St Arl Va Date signed April 27/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

### 1. PLACE OF DEATH:

County Prince George  
City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 11 hrs. 20 min.  
Hospital, institution, or street address where death occurred:  
Prince Georges General  
How long in hospital or institution? 11 hrs. & 20 min.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Berwyn  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2510 50th ave.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Waldemar Werber

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Oct. 3 1879  
8. AGE: Years 68 Months 5 Days 29 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace South Carolina  
(Town, county, and state)

10. Usual occupation Insurance agent

11. Industry or business Mass. Casualty Ins. Co.

FATHER 12. Name Frederick Werber  
13. Birthplace Newbury S.C.

MOTHER 14. Maiden name 7 Roach  
15. Birthplace Georgia

16. Informant Frederick S. Werber

Address 8510 50th an Berwyn Md

17. Burial Date thereof April 3 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln bury

Location Bladensburg Md

18. Funeral director X Hayes Co.

Address 2901 14th St N.W.

19. April 2 19 48 James Berney  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 1 April 19 48 at 8:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1948 to April 1948 and that I last saw him 17 April alive on 1 April 19 48

Immediate cause of death Pulmonary congestion  
Chronic myocarditis,  
Arteriosclerosis

Due to Myocardial infarction 59R +

Due to vascular renal

depression

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.L. Etienne M. D. or other

Address Berwyn Md Date signed 4/2/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

04134

131a

RECEIVED

APR 5 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04135 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 month, 25 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution?..... 1 month, 25 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 651 Second Street, N. E.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

CLARISSA M. WHITTAKER

## 3. (b) Social Security Number

-

4. Sex..... Female  
 5. Color or race..... Negro  
 6.(a) Single, married, widowed, or divorced..... Separated  
 6.(b) Name of husband or wife..... John G. Whittaker  
 6.(c) If alive, give age..... 27 years  
 7. Birth date of deceased (mo., day, yr.)..... January 10, 1925  
 8. AGE: Years..... 23 Months..... 3 Days..... 12 If less than one day..... hrs. .... min.

9. Birthplace..... Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation..... Housewife  
 11. Industry or business..... - - -

12. Name..... George Harris  
 13. Birthplace..... Cumberland, Maryland  
 14. Maiden name..... Nellie Moore  
 15. Birthplace..... Dover, Virginia

16. Informant..... Deceased  
 Address.....  
 17. Removal..... Date thereof..... April 23, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....

Location.....  
 18. Funeral director..... Stewart's Funeral Home  
 Address..... 30 H St N.E. Wash D.C.  
 Apr 23 1948 Rowland P. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 4/22 1948 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/27 1948 to 4/22 1948.  
 and that I last saw him alive on 4/22 1948

Immediate cause of death..... Pulmonary Tuberculosis

## DURATION

3 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE..... Daniel Leo Pinicane M.D.

M. D. or other

Address..... Glenn Dale Md. Date signed 4/22/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04136

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Benz Orange  
 City or town Riverside, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 51 hours  
 Hospital, institution, or street address where death occurred:  
Eugene Deland Memorial Hosp.  
 How long in hospital or institution? 51 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's  
 City or town Wilm Vale  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mrs Sarah Willitt

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Rennell Sanford Willitt  
 7. Birth date of deceased (mo., day, yr.) July 11, 1879 8. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 68 Months 9 Days 16 hrs. \_\_\_\_\_ min. \_\_\_\_\_  
 9. Birthplace Charles County, Md.  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 12. Name Benjamin Daniel Willitt  
 13. Birthplace Maryland  
 14. Maiden name Sarah Jane Nettie  
 15. Birthplace Maryland  
 16. Informant Chart

17. Burial Date thereof May 1, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St Pauls Cemetery  
 Location Waldorf Md.  
 18. Funeral director F. Beach Co  
 Address Hyattsville Md.  
 19. May 1, 1948 Mrs. J. S. Severe  
 (Date rec'd by registrar) (Signature of Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 19 48 at 9:45 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18 19 44 to April 27 19 48  
 and that I last saw him alive on April 27 19 48

Immediate cause of death Cancer of Uterus DURATION 10 years  
and abdominal malastasia 6 mo.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. C. May Jr M.D. or other \_\_\_\_\_  
40 r. from St. James Rd Date signed 4/21/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04137

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 yrs., 10 mos., 15 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 3 yrs., 10 mos., 15 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington, D. C.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1338 D. Street, N. E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

KATHERINE WILSON

### 3. (b) Social Security Number

235-32-4001

4. Sex Female  
5. Color or race White  
6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife -  
6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) November 18, 1923

8. AGE: Years 24 Months 5 Days 4  
If less than one day hrs. min.

9. Birthplace Spencer, West Virginia  
(Town, county, and state)  
Clerk

10. Usual occupation -  
11. Industry or business -

FATHER 12. Name R. F. Wilson  
13. Birthplace Zoma, West Virginia

MOTHER 14. Maiden name Violet Evans  
15. Birthplace Zoma, West Virginia

16. Informant Deceased  
Address

17. Burial, cremation, or removal, Which? Burial to Alexandria Va April 22 1948  
Date thereof (month) (day) (year)

Cemetery or crematory  
Location

18. Funeral director W. J. Cunningham  
Address 809 Cameron St. Alex. Va.  
4/22/48

19. (Date rec'd by registrar) 19 Rowland S. Phillips Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 22 1948 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6, 1944 to Apr. 22, 1948  
and that I last saw her alive on Apr. 21, 1948

Immediate cause of death Pulmonary Tuberculosis  
DURATION 3 yrs. 11 mo.

Due to  
Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings of autopsies  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinneaux M.D.  
M. D. or other  
Address Glenn Dale Md, Date signed 4/22/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 30 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04138

Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 mos., 15 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 3 mos., 15 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1001 M. St., N. W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

WILSON SADIE

### 3. (b) Social Security Number

578-30-6430

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Negro Married

6.(b) Name of husband or wife Robert Wilson

7. Birth date of deceased (mo., day, yr.) November 5, 1920  
6.(c) If alive, give age 28 years

8. AGE: Years Months Days If less than one day  
27 27 5 19 hrs. min.

9. Birthplace St. Johns, South Carolina  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Willie Wilson

13. Birthplace St. Johns, South Carolina

14. Maiden name Ella Carter

15. Birthplace St. Johns, South Carolina

16. Informant Deceased

Address

17. Removal Date thereof April 24, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director H. M. Horton Co.

Address 1322 1st St NW Wash.

19. April 24 1948 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/8 1948 to 4/24 1948  
and that I last saw him alive on 4/24 1948

Immediate cause of death pulmonary tuberculosis DURATION 6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel L. Fineman M.D.

Address Glenn Dale Md. Date signed 4/24/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH.

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Prince George County  
 City or town Riverdale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 days  
 Hospital, institution, or street address where death occurred:  
Selander Memorial Hospital  
 How long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County District of Columbia  
 City or town Washington D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3424 Garrison St. Wash. D.C.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

Albert Theodore Winter

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Emma Shaul  
Winter 6. (c) If alive, give age deceased years  
 7. Birth date of deceased (mo., day, yr.) December 8, 1860  
 8. AGE: Years 87 Months 4 Days 15 If less than one day  
hrs. min.

9. Birthplace Germany  
 (Town, county, and state)  
 10. Usual occupation Retired - Carpenter & Cabinet Maker  
 11. Industry or business —

12. Name Not known - Mr. Winter  
 13. Birthplace Germany  
 14. Maiden name Caroline Friedemann Winter  
 15. Birthplace Germany

16. Informant Mrs. Carrie Emma Winter Lacey  
 Address 3424 Garrison St. N.W. Wash. D.C.

17. Removal Date thereof April 23 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Donner's Grove Cem.  
Donner's Grove Dec.  
 Location Martin W. Hyslop Co.

18. Funeral director Martin W. Hyslop Co.  
 Address 1300 K St NW

19. April 23 1948 James Leray  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1948 at 8<sup>00</sup> a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1 1944 to Apr 23 1948  
 and that I last saw him alive on Apr 22 1948

Immediate cause of death Constrictive Heart Failure DURATION 1 week  
Arteriosclerotic Heart Dis 10 yrs

Due to —  
 Due to —  
 Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —  
 Date of op. —

Autopsy results —  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide — Date of —  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE L W Malin MD M. D. or other  
 Address Riverdale, Md Date signed 4-23-48

**RECEIVED**

APR 24 1948

**BUREAU V. S.**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04140

245

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Queen Chapel Manor  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

James Wissman4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.) April 15 - 1937

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years 11

Months

Days 1

If less than one day

hrs.

min.

9. Birthplace Washington, D.C.  
(City, town, county, and state)10. Usual occupation None

11. Industry or business

FATHER

12. Name Bernard Wissman13. Birthplace Brown, Maryland

MOTHER

14. Maiden name Emelda Wolf15. Birthplace Dublin, Ireland16. Informant MotherAddress 5615-31<sup>st</sup> Ave Queen Chapel Manor17. Burial

(Burial, cremation, or removal, which?)

Date thereof 4/19/48

(month) (day) (year)

Cemetery or crematory Cider Hill CemeteryLocation Swirland Md.18. Funeral director Timothy HanlonAddress 641-14 St N.E. Wash. D.C.19. April 16

(Date rec'd by registrar)

19 48

Mo. (as severe)

Deputy Seal

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Prince GeorgeCity or town Queen Chapel Manor  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5615-31<sup>st</sup> Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 19 48 at 6:20 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 30 19 48 to April 16 19 48and that I last saw him alive on April 16 19 48

Immediate cause of death

Acute myelogenous leukemia

DURATION

2 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Charles Dick, M.D.

M. D. or other

Address 4314 Gallatin St.Date signed 4/16/48Styano villa Md.



FILE No. G 115 APR 20 1948

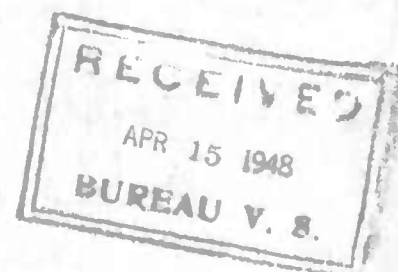
75c

Reg. Dist. No. 231

Address ..... Date signed .....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04142 243

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 6 mos., 27 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution?..... 6 mos., 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 1708 4th Street, N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

ESPERT WORTHY

## 3. (b) Social Security Number

578-12-1921

4. Sex..... Male  
 5. Color or race..... Negro  
 6. (a) Single, married, widowed, or divorced..... Married  
 6. (b) Name of husband or wife..... Janice Weldon Worthy  
 6. (c) If alive, give age..... 38 years  
 7. Birth date of deceased (mo., day, yr.)..... February 20, 1900

8. AGE: Years Months Days If less than one day  
 48 48 2 0  
 hrs. min.

9. Birthplace..... Chester, South Carolina  
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... - - -

12. Name..... Litton Worthy  
 13. Birthplace..... Chester, South Carolina  
 14. Maiden name..... Lizzie Land Worthy  
 15. Birthplace..... Chester, South Carolina

16. Informant..... Deceased

Address.....  
 17. (Burial, cremation, or removal, Which?)..... Removal Date thereof..... 21-20-1948  
 (month) (day) (year)

Cemetery or crematory..... Washington D.C.  
 Location.....

18. Funeral director..... Malian & Sales, Inc.  
 Address..... 424 - R St N W.

19. Apr. 20, 1948 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 20 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 1947 to April 20 1948  
 and that I last saw him alive on April 20 1948

Immediate cause of death..... Pulmonary Tuberculosis  
 DURATION..... 10 months

Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... Daniel H. P. Pincus MD  
 M. D. or other  
 Address..... Glenn Dale Md Date signed..... April 20, 1948

RECEIVED

APR 24 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04143  
245

## 1. PLACE OF DEATH:

County Pr. Geo. Co.  
 City or town Riverdale Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Seland Memorial Hospital  
 How long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md. County Pr. Geo. Co.  
 City or town Brentwood Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4010 38th  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Sophia Goraschek

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Bruno Goraschek

## 7. Birth date of

deceased (mo., day, yr.)

Jan 26 - 1872

## 8. AGE:

Years

Months

Days

If less than one day

76

hrs.

min.

## 9. Birthplace

Germany

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## MOTHER FATHER

## 12. Name

?Hessenaue

## 13. Birthplace

?Germany

## 14. Maiden name

?Hessenaue

## 15. Birthplace

?Germany

## 16. Informant

Janice Garkmeyer

## Address

4010 38th St. Brentwood Md.

## 17.

(Burial, cremation, or removal, Which?)

Date thereof

April 20 1948

## Cemetery or crematory

Woodlawn Cem.

## Location

New York City

## 18. Funeral director

J. H. Shires Co.

## Address

2901 14th N.W.

## 19.

April 19 1948James Sevor

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

April 19 1948

## 21. I CERTIFY the death occurred on the date above stated; that I attended deceased from

April 2 1948 to April 19 1948and that I last saw him alive on April 19 1948

## Immediate cause of death

Cerebral hemorrhage

## DURATION

10 ds

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of Injury

Injured at work?

## 23. SIGNATURE

Leonard Hays  
Hyaltsville, Md

M. D. or other

Date signed 4-19-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 21 1948

BUREAU V. S.



Mrs. Sophia, Yerasheuk,

4010 - 38 st

Brentwood Ind

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04/44 245

### 1. PLACE OF DEATH:

County Prince George's  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 years  
Hospital, institution, or street address where death occurred:  
6909- Woodland Ave  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6909- Woodland Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Frank William Young

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced divorced

6.(b) Name of husband or wife  
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1907  
8. AGE: Years 41 Months Days If less than one day hrs. min.

9. Birthplace Michigan  
(Town, county, and state)

10. Usual occupation Grant and Rods America

### 11. Industry or business

12. Name George Young  
13. Birthplace Ottawa, Canada  
14. Maiden name Estelle V. Cox  
15. Birthplace Canada

16. Informant Martin Friedman  
Address 3416 A Street S.W., Washington D.C.

17. Burial, cremation, or removal. Which? Burial Date thereof May 30, 1948  
(Month) (day) (year)

Cemetery or crematory Edgar Hill Cemetery  
Location National Capital Memorial Park Washington D.C., Maryland, Md.

18. Funeral director Arthur Stallers  
Address 257 Carroll St. N.W., Thomas Park, D.C.

19. April 30, 1948 Mrs. Jas. Severe  
(Date rec'd by registrar) Deputy Social Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1948 at 10:54

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Acute congestive heart failure  
Due to Cardiovascular disease  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner  
Arthur D. Taylor M. D. or other  
Address 7 Chestnut St. Date signed 4-30-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

